IN THE CIRCUIT COURT OF THE
SIXTH JUDICIAL CIRCUIT IN AND FOR
PINELLAS COUNTY, FLORIDA
CASE NO.: 97-5968-CI-11

JOHN EASTMAN,

Plaintiff,

vs.

BROWN & WILLIAMSON TOBACCO CORP., individually and as successor by merger to THE AMERICAN TOBACCO COMPANY, a foreign corporation; PHILIP MORRIS, INCORPORATED, a foreign corporation,

Defendants.

BEFORE: HONORABLE ANTHONY RONDOLINO
PLACE: The Judicial Building
545 First Avenue North
St. Petersburg, Florida
DATE: Thursday, March 20, 2003
TIME: 8:54 a.m. - 11:41 a.m.
REPORTED BY: BETH L. BILLINGS, RPR
Court Reporter and Notary Public
Sixth Judicial Circuit

TESTIMONY AND PROCEEDINGS

Volume 18 Pages 1877-1998
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I N D E X T O P R O C E E D I N G S

(8:53 a.m.) P-r-o-c-e-e-d-i-n-g-s

THE BAILIFF: All rise, please. Court's in session

THE COURT: Good morning.

MR. ACOSTA: Good morning, Your Honor.

THE COURT: We ready to proceed with the jury at 9:00 this morning?

MR. ACOSTA: I think so, Judge.

THE COURT: Okay. Is there anything we need to do before we bring them?

It's not really quite 9 o'clock yet.

What's the order of business for today?
MR. ACOSTA: We have a treating doctor, and then we have some -- some more video. And then we may have some depositions to publish. And that looks like the order of business.
THE COURT: All right. I have a meeting at 4 o'clock, so we may have to recess a little early today.
MR. ACOSTA: That would be great as far as I'm concerned.
THE COURT: I have also received this morning a defendant's motion to strike portions of Dr. Farone's testimony.
MR. LYDON: I'm sorry. I believe that was

probably --
MR. ACOSTA: Can I run out and go to the restroom, Judge?
THE COURT: Sure.
MR. ACOSTA: I'll be right back.
THE COURT: Mr. Wallace and Mr. Parrish never visited Peggy this morning.
MR. WALLACE: Can I run in real fast?
THE COURT: Sure, you can.
MR. PARRISH: Thank you for the reminder.
MR. WALLACE: Thank you, Your Honor.
(Pause.)
THE COURT: All right, Mr. Acosta, you ready to have the jury brought in?
MR. ACOSTA: Yes.
THE COURT: Sheriff, let's do that.
(The following took place in the presence and hearing of the jury.)
THE BAILIFF: Jury is in the jury box seated, Your Honor.
THE COURT: Thank you very much, Sheriff.
Welcome back, ladies and gentlemen. We are ready to move forward today.
Mr. Acosta?
MR. ACOSTA: May it please the Court.

Dr. Stephen Groff.
THE BAILIFF: Doctor, stand right here and receive the oath from the clerk.
Thereupon,
STEPHEN GROFF, M.D.,
was called as a witness and, after having been first duly sworn/affirmed to testify the truth, was examined and testified as follows:
THE WITNESS: I do.
THE BAILIFF: Step this way, please.
Have a seat in the witness chair. Watch your step. Speak in a clear and loud voice.
There is some fresh water there if you need it.
THE WITNESS: Thank you.
Okay.
DIRECT EXAMINATION
BY MR. ACOSTA:
Q. Good morning.
A. Good morning, sir.
Q. Would you please tell the jury your name and where you live?

A. My name is Stephen Groff, and I live here in downtown St. Petersburg.
Q. And what's your occupation?

A. I'm a physician specializing in psychiatry.
Q. And how is it that you came to be involved in your testimony here today?
A. Well, John and I have known each other for a long time. And in most recent years he has contacted me and we have kept some contact. And very recently I received a subpoena for my records. And when I provided those records, I then found out that there was this trial going on. And I guess the next thing I heard was from you who asked me if I would come and testify to my treatment of John.
Q. Did I hire you as an expert witness?
A. No, I'm not an expert witness here, just a treating physician.
Q. And what's the difference between a treating physician and someone who is hired -- first let me ask you this. Have you ever testified as an expert witness in the past?
A. Yes, I have.
Q. Okay. What's the difference between testifying as an expert witness and testifying as a treating physician?
A. Well, you can actually be both, except if you have never seen the patient as a treating physician, then you would be asked because of basic expertise in

the area of psychiatry or some subspecialty of psychiatry to give expert testimony.
If you are a treating physician, you can be asked to just limit yourself to that which you have done as a treating physician.
Q. Can you tell the jury -- jury what a psychiatrist is?
A. Well, a psychiatrist is a physician, just like any other physician. For example, I have delivered babies, I have done surgery, rotated through all the subspecialties of medicine. And then at some point in your career you decide what specialty you would like to do further, and I chose psychiatry. And then you do a rotating internship through the specialty of psychiatry, as well as through all the other specialties, and then follow that by extra special training in the sense of residency training in -- specifically and only in the field of psychiatry.
In addition, not always, but in my case as well, you can do analyses which train you for further psychotherapeutic treatment.
Q. Can you tell the jury your educational background?
A. Yes. Well, actually I should start in college. I was a physiology major with a minor in

psychology starting back in 1950. And I interrupted my training during the Korean War when I enlisted in the military.
After being separated from military service, two years of active duty, I was in the military reserve for another six years. And during that time I traveled extensively in Europe. It was in Europe where I came

upon the professor of physiology at the University of Amsterdam who offered me a position.

So I returned to the states, completed by bachelor's degree in physiology and went to work for this professor at the University of Amsterdam as an instructor. It was there where I became much more enamored in the fact of acute medicine in the subject of medicine and treatment and ultimately in October of 1964 I achieved by medical degree.

After my medical degree I spent about -- a little more than a year doing rotating internships, which led to a degree there known as the semiarts. This was followed by another year and a half of rotating internships. And this met the requirements for the United States Board of Medicine, which was known as the Educational Council for Foreign Medical Graduates. And I took that which then made me eligible to take my boards for the state of Florida, which I believe I took

back in 1970.

And that was followed by specific training in the field of psychiatry, three years of residency training. The first year was at the University of Miami, Jackson Memorial Hospital; and that was followed by two years at the Hillside Hospital in Glen Oaks, New York, which brought me to 1971. After which time I was invited to come down here to teach at the University, and I did for a number of years. And then went into private practice, and I have been self-employed in private practice since that time.

Q. What department of the university, and which university down here did you teach at?

A. USF for the department of psychiatry. I was an assistant instructor.

Q. Did they have a medical school there?

A. Yes, that's in the medical school, correct.

Q. And where is it that you delivered babies and performed surgeries, and things like that?

A. Well, that was during my training in Holland. As part of my rotations rotating through OB-GYN, we were required to deliver at least 30 babies as part of our training. And I actually delivered 36, I believe.

Q. Now, what is the difference between a psychiatrist and a psychologist?

A. Well, as I explained some of my background and training, which includes getting an undergraduate degree from a college, and then actually I had a minor in psychology. Then going on to medical school and internship and then residency, if not further analysis, a psychologist would graduate from college and then start studying only psychology, usually doing a master's first and then going on to what's known as a Ph.D. in psychology. So they had no medical training, no medical school basis for their work.

Q. What is the purpose of psychiatry? Your field, what is it that you do?

A. The purpose of psychiatry is just like any other physician, to evaluate a patient's problems as they are referred to you. But more specifically not only looking at the body, but also looking at the mind more specifically, whereas, for example, a neurologist or another physician would not be as interested in --

although they do do a minor mental-status study, or something like that, it wouldn't be as extensive.

So although with our background and training we are doing just what any other doctor does, as part of a history, we would be more limited to the matters, usually for the referral purpose of something, that was more in the area of the mind.

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Q. Can you explain what you mean "by the mind" as opposed to the brain?

A. Well, the brain, as anybody recognizes, is the more physical and tangible. The mind is that which is intangible, which is often a little confusing to people because one would think that since something is intangible, therefore it is much more difficult and nebulous to work with.

However, through the science of medicine, of which psychiatry is obviously one portion, the tools that we use are every bit as tangible as we would like to think, even the scalpel of a surgeon. So in that sense, speaking about the mind and the way we approach the mind and the tests that we do through clinical knowledge or even actual psychometric testing deals with it as a very tangible and concrete item, not abstract and intangible.

Q. Can you describe some of the tools that you use to diagnose mental disorders?

A. Sure. First and foremost, one begins with everything that they've studied and learned about the body, about the mind. And this gives you a fund of knowledge upon which you base your clinical evaluation. Then of course, you have experience that you have gained in internships and residencies, and not the least of

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which is through actual practice.

Now, while evaluating a patient, you are not only using the background of everything that you have learned from your teachers, from your books, and from your development as a therapist with your patients, but you also have certain tests you could call them. For example, we use the mental status examination whereby we evaluate a person by sometimes asking them very specific questions, much so as a neurologist might do who also wants to know about intangible things in the brain.

For example, you may know that different parts of the brain are responsible for different functions, speech, color, sight, but also certain emotional things in the brain. And as time goes by from science and chemistry, we understand more and more about how the brain function and therefore how the mind functions and what emotions are created; like depression, like anxiety.

So by asking these questions and using these tools, we are able to actually localize in the brain where the seat of emotion might lie or where the seat of some disturbance might lie. And in that fashion, we use these tools to make a diagnosis.

Q. Now, are you trained in the field of physiology or brain chemistry?

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A. Yes. Basically my roots began as a muscle-nerve physiologist. And this is before I became a medical doctor and doing work on conditioning.

It so happens that I had a lot of expertise in that, so by the time I came out of the military and had met Professor Ten Cate, who is kind of a world famous physiologist, with his wife, he thought it would be interesting if I could go and do work with him.

You may or might not know that in Russia, for example, where he came from, that conditioning was the first roots of psychiatry before the basic tenets of what we now call psychoanalytically-oriented psychotherapy or Freudian, if you will, type of psychotherapy was developed. So that these were the basis items to study further the field of psychiatry.

As time went by, especially let's say in the mid-'50s through tremendous discoveries in the field of psychopharmacology, I was involved in research right from the beginning in psychopharmacology. Now we had chemicals for the first time which we understood could affect the brain. And if we had chemicals that could make people be unusual or psychotic, as you might describe it, out of touch with reality, and we could find antidotes to that, then possibly we could find cures for some of these illnesses.

So in the '50s it was just a boom time for psychopharmacology and the advent of both finding chemicals, as well as being what we call the "talking therapy" to help patients.

So to summarize it very simply, what used to be known as only the "talking doctor," who could only deal with the person and help them try to get in touch with things that they might have been doing that's self-destructive and not aware of it, the course of the talking, if done in a very special scientific way, as we were taught in the principles of psychoanalysis, would help a person bring those things up, now we had chemicals as well, which made things easier. So we rapidly found out that one alone wasn't as good as both together.

Q. Can I back up to near the beginning of your answer and ask you, what -- what is conditioning?

You mentioned that term "conditioning" that you were involved in that and had special expertise in it. What is that all about?

A. Well, I think many people would associate the name of conditioning with a professor named Pavlov. And the idea was at that time that you could take an unconditioned stimulus and by repeating it have it become a conditioned stimulus.

And you might be more familiar with it in the sense of you have a dog, and we redid all of these experiments because this professor was actually the last living pupil of Pavlov, so I had the honor to work with him. If you have a dog and put meat in front of it, he began to salivate.

If you paired together the demonstration of meat to the dog with ringing a bell and continue that enough, that eventually you could remove the meat and only by giving the ringing of the bell, you would get the salivation.

So what you had done was taken an unconditioned stimulus, showing the meat, and having the dog salivate, pairing it with a conditioned stimulus,

which was the ringing of the bell, you soon could take away the bell. And then just by -- excuse me, the meat, and then by ringing the bell, the dog would salivate. So you had created a conditioned stimulus.

Now this person -- or the dog rather -- and it works in people as well -- obviously we studied dogs, but this person then developed somewhere in -- someplace in your brain this concept of your ringing a bell and they getting a response. So where was that?

Well, that's when we began to think about there must be someplace known as the unconscious wherein

this information is stored.

Now in the very same way --

Q. Can I stop you for a second first?

A. Sure.

Q. Is a conditioned response the same thing as a habit?

A. Yes, you would say that.

Q. And is it -- is the -- this conditioned response something that is -- the person is necessarily aware of?

A. Well, to coin the expression, they would necessarily not be aware of it because it had been so -- as we would say "brainwashed" or "slipped in" without them really realizing what they are doing, so that before long this person would be doing this. To use the parable of the salivation and the ringing of the bell, but no longer having any idea of why they are doing that.

Q. Are there examples of human behavior that might be considered conditioning that you might --

A. Yes, the whole idea of addiction, for example, would be explained by a similar function and fashion, except that we now have expanded that even further, not just using the principles of conditioning, but going into psychiatry, the medical aspects of psychiatry, if

you will, the psychodynamics of psychiatry where we have actually pinpointed where this sits and what kinds of psychic apparatus or mental mechanisms of defense actually cause this to happen. So we have gone beyond that now to understand it more.

Q. All right. I want to ask you some questions about that more in a few minutes. But before I do that, I wanted to ask you a little bit more about your background and qualifications.

Do -- as a psychiatrist, how long have you been in the Tampa Bay area?

A. Since 1971.

Q. And how -- would you mind telling the jury how old you are?

A. March 22nd I will be 70.

Q. 70. Okay. And do you still practice?

A. Yes.

Q. And do you have an office?

A. Yes.

Q. And where is that?

A. 4522 Spruce Street in Tampa.

Q. And over the past 31 or 32 years, have you treated patients on a daily or weekly basis?

A. Yes.

Q. And what kinds of patients have you seen over

the years?
A. Truthfully, all kinds of patients, which includes hospitalized patients who suffer from major mental disorders, neurotic patients who suffer from depression and anxious and personality disordered patients. And that covers the whole gamut of every kind of patient you could see. I have also seen children.
Q. And have you --
A. Yes.
Q. Have you been involved in work as a staff member at any hospitals?
A. Yes.
Q. In what way?
A. Actually -- well, the first private psychiatric hospital that was made in Tampa, I was actually one of the original people in that. We started out -- it was called Riverside Hospital. We had 8 beds and eventually it grew to Tampa Hospital. Within a short period of time, I no longer received the gratification or interest in hospital work, and I kind of reduced my practice to totally outpatient work in more recent years. But I believe that hospital was sold and became Charter Hospital and maybe even something else now. So, the last time I actually dealt with inpatients was probably 20 years ago.

Q. Now, do you have any other areas in medicine that you are licensed or certified to work in? For example, do you have anything to do with aviation?
A. Oh, yes, aviation has always been a very important part of my life. And I have been a federal aviation agency medical examiner for some 30 -- more than 30 years. And of course, throughout the years doing all the certifications, I've always taken additional courses, and I was an FAA medical review officer for drug addiction and I have expertise in that area.
Q. Now, have you published any papers in the field of psychology -- I mean, excuse me, psychiatry?
A. Yes, I have. Going back to when I worked for Dr. Donald Kline at the Hillside Hospital -- excuse me, we were the principal investigators doing the work on methylphenidate, which was Ritalin, which at that time was not known to be a better choice than let's say amphetamines for the treatment of Attention Deficit Disorder. And I was also very interested in the area of panic disorder and published in that area. Oddly enough, both of these areas had to do with children. And although I'm not a child psychiatrist, I had -- because of my psychopharmacological research with Dr. Kline, I had expertise in that particular area.

As a matter of fact, the thing that originally brought me down to Tampa, although I never did it, was that I was working on a depression rating scale for children. And that -- with this new university. At that time in '71, I don't think they had graduated their first class. I was supposed to come down and be in charge of research and things like that. And ultimately, I just didn't stay with the university and got more involved, having my own family to raise and three children, in private practice. And I have never

gone back to research, so I haven't published since that time.

Q. Okay.

A. Although I'm thinking about it now.

Q. I'm not sure if you are speaking to fast for the court reporter or not --

A. I'm sorry.

Q. -- but maybe slow down just a tad would -- might be helpful for her.

Now, you mentioned, I think, the term "unconscious mind." Do psychiatrists look at the mind and divide it up into varies categories, for example?

A. Yes.

Q. And can you explain how that -- how you do that or why you do that?

A. Yes. It's very simple, really. It sounds more ominous than what it is. The only reason I gave a little background on conditioning was so that anyone could identify with the concept of you think you could almost remember something and then it's on the tip of your tongue and you remember it or that ringing of the bell, where is it stored. So, it must be someplace in your brain. And we would like to now recognize that that someplace that you're not quite in touch with is called the unconscious. Then there's obviously a part of the brain that's conscious, such as we are talking now with each other. And last but not least, it was postulated as part of the psycho dynamic apparatus that there is a superego wherein resides the conscience.

So, the idea was that if you had some unconscious drives that wish to find their way into your consciousness, that there needed to be some kind of watchdog called a conscience that would say, be careful now, if you do that, you will experience shame or guilt. So, that explained the necessity for these three areas, the conscience, the conscious and the unconscious.

Now --

Q. What is a drive?

A. Well, Dr. Freud postulated a long time ago that there were some things that weren't put in there by

experience or knowledge, and those were your basic instincts. And for the work that he did in his time, he postulated that there were two instints or drives. And by naming those two instincts, the first one many of you may recall from either literature or whatever, were the sexual drives that were there for survival, self-preservation, reproduction. And then there were the aggressive drives which he later postulated as an attempt to explain things like Obsessive/Compulsive Disorder.

So as you know, Dr. Freud is dead and as far as we know, no one else has postulated any other instincts attributable to human beings other than the sexual and the aggressive drives which reside in the unconscience.

Q. All right. And --

A. Can I give you an example that just crossed my mind?

Q. Yes.

A. So I might make it clearer for the jury.

Q. Sure.

A. One would wonder, well, what does a sexual drive have to do with smoking cigarettes? Well, in analysis one might come up with --

MR. WALLACE: Objection, Your Honor. The

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witness is now asking himself questions and answering them. May we approach?

THE COURT: Well, perhaps this is the way the witness explains his thought processes in terms of coming to an opinion.

MR. ACOSTA: He asked me if he could give an example and I said yes.

MR. WALLACE: May we nonetheless approach briefly, Your Honor.

THE COURT: Okay.

(Proceedings at the bench follow.)

MR. WALLACE: Mr. Acosta is planning to do -- he's qualifying this gentleman as an expert after the witness himself has explained that that's not what he is here to do. He has now been on the stand for 25 minutes. He has not mentioned John Eastman's name once except to say they are friends. And I think what he is doing here is inappropriate. He brought him here as a treating physician and he is qualifying him now as an expert in addiction since he clearly needs some help in that area. And I object.

MR. ACOSTA: I'm simply asking him questions so that the jury will understand what he does and what he did. I don't think you can do that unless

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you know what his field is. It would be just like asking, you know, a neurologist to explain his background and training and what the field of neurology is.

THE COURT: I'm assuming you're going to be offering this witness's opinions about --

MR. ACOSTA: Mr. Eastman.

THE COURT: -- the subject.

MR. ACOSTA: Yes.

THE COURT: And he is an expert witness --

MR. ACOSTA: Yes.

THE COURT: -- because of his special education, training and experience. He happens also to be a treating physician, so he has some fact knowledge about the case.

MR. ACOSTA: Uh-huh.

MR. WALLACE: Yes, Your Honor, but this gentleman has not been disclosed as an expert witness in this case. He disclosed his addiction expert and we deposed him and we cross-examined him. And now he is seeking to have another witness address that who he has not disclosed. He disclosed Dr. Groff as a fact witness and treating physician.

THE COURT: Well, I'm assuming as being a

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treating physician, you were aware that he was going to be talking about his treatment of Mr. Eastman.

MR. WALLACE: He hasn't done that yet, Your Honor. He is talking about the roots of psychotherapy, psychoanalysis.

MR. LYDON: We're never --
MR. WALLACE: We're never going to get to the treatment.
THE COURT: Well, do you want to do it the other way where he talks about his treatment first and then explains the basis for his knowledge and opinions?
MR. WALLACE: Well, why is he -- well, where are we going, I guess, would help. How long does Mr. Acosta plan to go with him before we get to what he treated Mr. Eastman for? That might be helpful.
MR. ACOSTA: I don't know. I don't think hours, but, you know, I'm just examining the witness and just asking him questions. He's making comments about things that I think need to be explained to the jury. When -- he answers a question and then he says, well, you know, conditioning is part. Well, I think the jury needs

to understand what conditioning is, that's all. So, I'm just conducting what I consider to be a standard normal examination of a treating doctor. This one just happens to be a psychiatrist.
MR. LYDON: What did he treatment him for?
MR. ACOSTA: And that's all.
MR. LYDON: What did he treatment him for?
MR. ACOSTA: We'll eventually get there. You guys have -- you guys subpoenaed his records.
MR. WALLACE: No diagnosis in his records whatsoever. What did he treat him for?
MR. ACOSTA: We'll get to that point, okay?
MR. PARRISH: This is totally a surprise.
MR. ACOSTA: They had -- they could have taken his deposition if they wanted to. In fact, they set his deposition and then cancelled it. And then I tried to call him -- call him back and I said, you know, look, are you sure you really don't want to take his deposition? Because I was trying to plan my case as well. And so, they decided not to take his deposition. That's -- that's up to them. So I -- you know, I'm just asking questions of the doctor and I think they're perfectly standard normal unobjectionable questions.
MR. WALLACE: Well, clearly what -- clearly

they are objectionable because we are objecting to them, and the fact that you don't think they are doesn't mean they are non-objectionable.
The second point, Your Honor, is we did express an interest in taking this gentleman's deposition. He refused to sit for us unless we paid him a minimum of $1,500 and then -- basically $1,000 an hour thereafter. So, we opted not to take his deposition.
MR. ACOSTA: And I spoke with him and then I told them that he would do it for $600 an hour, which is the same that Dr. Back charged them and they agreed that $600 an hour would be a reasonable time. And then they said, well -- and then he said he wanted to do it for two hours and then he said, no, I'll even do it for an hour. And I called Mr. Lydon and told Mr. Lydon that he would sit for

an hour at $600. That's all he needed. But that was -- that was what the deal was and they chose not to do it. You know, they paid Dr. Back $600 an hour, so I don't know what the problem is.

MR. LYDON: I would still like to know what he went there for and how it's relevant to this.

MR. ACOSTA: Well, I think we'll get there. He treated him for seven months.

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MR. WALLACE: For what?

MR. ACOSTA: You'll find out.

MR. WALLACE: Well, I don't think that's fair, Mr. Acosta.

MR. ACOSTA: You have his records and I have his records.

MR. WALLACE: He puts a witness on the stand and says, we'll find out what he treated him for. There is no indication in this man's records what he treated him for.

MR. ACOSTA: Well, then you can cross-examination him on that basis.

THE COURT: I don't know why we would wait until the middle of the witness's testimony to complain about not being able to take the witness's deposition. Certainly, if you'd wanted to take the witness's depo --

MR. LYDON: I'm sorry, Your Honor.

MR. WALLACE: We weren't complaining about it.

THE COURT: Okay. Well, I heard the word "surprise."

MR. LYDON: No, we're complaining about the fact that we have yet to hear that he went to him for any treatment that's relevant to this case.

THE COURT: Well, Mr. Acosta says he's going

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to be presenting that. And I don't think that you-all can control the order of the presentation of the testimony of the witness. I think he has every right to bring out the qualifications, the education, training and experience of the witness upon which the jury will be advised that they are to determine how to weigh the credibility and weigh the testimony of this expert witness. So, I'm going to permit him to do that.

If you think that this is some sort of surprise, I will have the jury taken out and you can ask the witness some questions. But it seems very remote to me that it could be Mr. Acosta's fault that it would be a surprise if the witness was revealed, his records were given to you and you were given an opportunity to depose him.

If there was a dispute over how much to pay him, those are matters the Court tends to regularly and the Court rules upon what's an appropriate amount to pay a witness for these discovery matters. So --

MR. LYDON: I didn't approach on that basis, Your Honor. I wanted to know how this is relevant.

THE COURT: Right. Well, that's what we have discovery for.

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MR. LYDON: And if we don't and if it isn't relevant, I suppose we'll get the ability to move

to strike his testimony.
THE COURT: I'm sure you're aware you have that ability. I've got a written motion here regarding the prior testimony.
MR. LYDON: Yes.
THE COURT: All right, proceed.
(Proceedings in open court follow.)
MR. ACOSTA: May it please the Court?
THE COURT: Proceed.

BY MR. ACOSTA:

Q. Dr. Groff, you were going to give the jury an example; do you remember what it was?

A. Yes. And I apologize for causing the delay. But, you know, as a psychiatrist, when you asked me about the instincts an I said the sexual and the aggressive, I had to kind of thinking, "Oh my God, I said sexual," so I thought I better clarify that.

And what I was going to explain was that, for example, what we mean when we say sexual is not in the strict sense of anything having to do with coitus or relations at that level. What I really meant was, for example, if you smoke a cigarette and the cigarette touches your lips, it's an oral zone of pleasure. So I

think we were talking about sexual in the sense of anything that leads to pleasure. And I just wanted to clarify that and I didn't mean we're limited only to sex, but really to pleasure.

Q. Okay. Now, you've mentioned these three parts of the mind, the unconscious, conscious an superego. Can you be aware of your unconscious thoughts?

A. No. By definition, the unconscious is that which you're not aware of. You cannot be aware of that which you cannot be aware of.

Q. And is there a way to find out what is in the unconscious?

A. Yes.

Q. And how do you do that?

A. That is the scientific tool that I was discussing earlier, the psychoanalytic process. So by this ingenious technique whereby we have learned through the decades of practice with results that when patients have in this, in quotes, "unconscious area" of the mental apparatus thoughts that they are not aware of, which -- and let's take the example of something that is self-destructive, bad, and they are an aware of it. As you use this technique of psychotherapy, the talking, yeah, possibly sometimes if you have depression or anxiety facilitated by chemicals which can help open up

those pathways, then you might, through the course of time, become aware of that which you formerly were not aware of. That is the entire goal of therapy.

So, if a patient came to you and had something he was not aware of and we could uncover that as being a cause of what's led to his symptoms and we then saw the person was getting relief and doing better and the person was able to verbalize, discuss it, not just one time like in Hollywood, but over an extended period of time and receive the benefit, then we could say that those things which were formerly unconscious have now been made conscious an the person, again, has an opportunity to make a choice about it now, whereas

before, they had no choice.
Q. Why is it that they had no choice?
A. Because this unconscious self-destructive behavior was out of their ability to be aware of it. So, if you would ask them about it, for example, a loved one would say, "Well, why are you doing this thing which is obviously bad for you?" They would make up what we call one of two mental mechanisms of defense. The less innocuous would be rationalization to make excuses for why it's okay, despite everybody knows it's not a good thing, like maybe picking at a sore on your skin or even worse. An that becomes part of a very deeply ingrained

type of bad behavior called denial.
And when I say "denial", I don't mean like when you look at Webster's Dictionary with a small D the way we use it in common parliaments, I'm using it as a capital D, a tool for psychiatrists to try to understand this mental mechanism of defense where a person is doing a thing that's extremely self-destructive, killing themselves, an yet would deny that they are doing it in the psychiatric sense, the scientific sense.
Q. Can I ask you, when you say that this is a mechanism of defense, is it a mechanism that they are aware of or that they consciously employ?
A. No. It's unconscious. It's totally unconscious, absolutely not conscious. It's kind of we say -- a little joke, for example: If someone walked up to someone and spit in their face and they might say, "Oh, I think it's raining outside." It's kind of a joke you tell medical students to give them the idea that it's preposterous. How could you think to say it's raining when somebody does such a horrible thing to you?
Well, I know it's not an easy concept for the layman to understand, but unconscious means you are not aware of it, but yet it's driving you surely as any other thing that happens in your body. Like you are not aware of your heart beating, and yet it goes on. You're

not really aware of your breathing, and yet it goes on. Well, this is a mental aspect that goes on without your being aware of it; not aware. If you were aware, you probably wouldn't do it.
Q. Is it known physically within the brain where this unconscious mind resides?
A. Well, when you say "known", that has to be explained. There are many, many theories. We know circuits, pathways, locations. And some things are known very particularly, but some things are not known as well.
For example, when it comes to panic disorder, we know very strongly through tests that in a certain area of the hypothalamus, a certain group of little cells called locus caeruleus, for reasons that probably go back to our primitive beginnings on this planet, send out signals of warning when a person, for example, gets lost. This person then, for the first time in their naive life, give out these signals of panic, like a child who needs retrieval. And then perhaps the parent or whoever is guarding that child can come and save that child. So we believe that special group of little cells that occurred lead to that first primitive response, which is a survival thing, anthropologically speaking.

Now, we have developed more modern parts of

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our brain. The frontal lobes which have to do with cognition, that was old brain. We have a newer brain which has a pathway from there to the front of your brain which you now remember consciously. And now all the time you're walking around with that conscious awareness of that terrible experience.

So if, for example, the theory goes that you should now come by a situation that originally triggered that bad response which you're not aware of, reversedly it sends back and starts stimulating that because you are now reminded of it by your present awareness. So that you might now consciously continue to avoid the location where that very first terrible experience occurred, even though there is no more danger there anymore.

Now, we know through ablation of certain areas, through neurosurgery, just -- that this happens more often as not, that certain chemicals reduce it, et cetera, et cetera. So, that's how we, in quotes, know.

Q. Now, you have mentioned a number of disorders; an neurosis, panic disorder. I think there may have been a couple others. Do you -- first of all, are those diseases, considered diseases?

A. There was a time in psychiatry when -- in the old diagnostic and statistical manuals, we adopted the

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European methods of calling everything disorders, diseases, reactions. So, it depends on how you want to use the word. But for our purposes, you could say, yes, they're disorders. Because diseases, people usually attach with bacteria. And these disorders are more brain functional things, which doesn't mean to say that bacteria can't affect the brain. But okay.

Q. All right. Well, these disorders that you've mentioned, do they have diagnostic criteria? In other words, how do you determine one from another?

A. Well, throughout the years, we have developed a manual known as the Diagnostic an Statistical Manual of Mental Disorders. And it has gone from one to two to three, which was about the time we were talking about, then it went to four, an at the present time, it's up to four slash TR, which is a text revision, an there are plans to make a five within the next ten years.

In these manuals, you'll see a development of exactly what I think you are asking of how, when we have a diagnostic category, there are symptoms and ways of determining who fits into these various categories. So that with the globalization of medicine around the world, if I were to pick up a phone and call somebody in France -- no, not France, call somebody in some other country, I would be able to communicate with them just

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by giving them the diagnostic number which we give a name and associated with it would be a whole bunch of symptoms an categories which would help us right away know we're talking about the same beast.

Q. Now in your practice, do you treat people with addictions?

A. Yes.

Q. Do you treat people for alcohol dependence?

A. Yes.

Q. Is -- what's the difference between dependence and addiction, if any?
A. Well, no. Actually, in the old DSM III, I think they would have spoken about addiction and certainly with the definitions of the World Health Organization and, as I said, with the globalization an trying to communicate with words. But today with the DSM IV TR, talks about as dependence is really an addiction; it's the same.
Q. Now at some point in time, did you have occasion to treat John Eastman?
A. Yes, I did.
Q. And how did your treatment of him come about?
A. Although I can't say exactly, I believe he must have called me and asked to set up an appointment and then he came to see me for the initial evaluation.

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Q. Had you met him before you saw him professionally?
A. No, I had not.
Q. Can you tell us what year it was that occurred?
A. Yes. That was in 1980.
Q. And in 1980, did he come to see you?
A. Yes.
Q. And what was the purpose of his visit?
A. Well, he said that he was having a poor reaction to the stress that was being caused by his occupation. Actually, John Eastman is a celebrity. He had a weekly radio show and a TV show an he was very well known in the Tampa Bay area, although at that time, I don't think I watched the show or listened to his radio show very much. But he was known to be a celebrity in this area. And as -- I assumed, as I had treated other celebrities, it was not something that was uncommon to me.
As a matter of fact, I had the occasion to treat as a group apart -- an they are a group apart when you deal with celebrities because they are unusual in the same way that adolescents, for example, are different than adults an children. They are a breed apart.

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He was evidently in the throws of having questions and being under stress because of his occupational situation; at least that's what we were talking about. And that's why he really came to me. Someone must have referred him to me.
Q. And then what -- well, first of all, when a patient comes to you an seeks treatment, what typically do you do and what's the course?
A. Well, the first thing that one does when a patient comes is you take a history, just like you would about any patient for any reason. And we have a pneumonic that I don't know if it's still being used, but we always used called "soap." And the S stood for the subjective complaints of the patient. Subjective because obviously we talked about the unconscious. Anything that a patient says is subjective. They cannot be objective about themselves. That's just a sine qua non.
Then it's up to the doctor, the O, to see what objective findings are there, be they physical. If I

were, for example, as a physician to see certain things that I thought were physical illnesses, a yellow jaundice of the eye that a patient was not aware of or some other physical things that's might be leading to an emotional mental thing, that would be a part of my

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objective findings. And then the psychiatric objective findings which are to talk about his state of mind, the degree of anxiety, the degree of depression, the degree of how he interacts with people. So, psychosocial.

Then the A stands for an assessment. When you have completed these first two things, his subjective complaints, your objective findings an you evaluate those, then you can come up with a working diagnosis. You say, well, amongst the differential diagnosis of many things ranked in the order of most likely to least likely, this is what I think is going on.

And then the last would be the P for soap, which would be to make a plan. An the plan would be laid out to make a course of therapy or to say to the person, look, you have nothing and we don't need to see you, there is nothing to do. Or if there is a plan that you think you could help the person with, you lay that out for them as well.

So, that's what would happen in the first or certainly early sessions if you couldn't get all of the information in the beginning.

Q. And did you follow that -- that plan with Mr. Eastman?

A. Oh, of course.

Q. And can you tell us what the history was that

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you recall of him that he gave you?

A. Well, I've notes that I took which have been described as cryptic, and I agree with that. I take in the beginning maybe more notes, and as time goes on, you don't want to be interfering with the relationship of the patient by writing. So I do have some scribbles which jog my memory and there are words there which maybe lead me to the next session, the next session.

And essentially, the first session was spent in talking about getting -- you know, you want to develop a relationship with the person once you have decided that you are going to see them, and by giving them the comfort of being interested and asking about their family, about their life, about things, but it isn't always directive. Sometimes you allow them to lead and make it comfortable.

So, I took notes about different statements an things that he told me all the time, most everything being in my brain formulating -- and I could never write down as much as I'm thinking, so that's more or less what happened.

Q. All right. Did you determine at the first or second -- first few visits, what your treatment plan with him might be?

A. Yes. Because of what he told me, I told him

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that I thought that we ought to meet on a weekly basis for individual psychotherapy.

Q. Are there other treatment options other than individual therapy or psychotherapy -- I mean, maybe not for him, but in terms of patients that come to see you,

what are the treatment options?
A. Well, it would depend on what's wrong with the patient. If I took it from its most stark for someone who was totally out of touch with reality, a schizophrenic, the treatment might include doses of strong medications which are antipsychotic, hospitalization and things like that.
For a patient who just had conflictual things an was suffering from anxiety or depression, you might choose or not choose to give a psychopharmacological agent to help reduce that and at the same time, do individual psychotherapy, possibly group psychotherapy, possibly marital counseling, family psychotherapy if it included children, and those would be some of the options. An then you might have a patient in whom you felt you could just give them something very minor an say, "See how you do on this and come back in a couple of months an see if any individual psychotherapy of a supportive kind was even necessary." So, it could run that entire gamut.

Q. Let me ask you -- I'm going to ask you more about Mr. Eastman, but I remembered something that I wanted to ask you. You mentioned that you treated addictions. Can you tell the jury what an addiction is?
A. Well, an addiction is when -- as we talked about conditioning earlier, when a person is exposed to a certain behavior, a certain characteristic movement, a certain way of doing things, and that person begins to continue to do that unbeknownst to themselves as to why they continued to do that, eventually we reach a point where that person is doing it more by rote, by habit, by condition, by addiction than by any kind of a choice that they would think about such as taking a bus; I will take a cab today.
Certain behaviors -- like we used to talk about in Korea about brainwashing. You can have a person where you wear them down and get them to believe a thought until eventually they forgot who planted the thought, but that thought is somewhere in that unconscious and it's driving them, moving them, and they are totally not aware. So, you would use that as, saying they are addicted to that thought, if you'll, but that would be a stretch. Most of the time, we use the word "addiction" to mean substances. Although, as you can understand, you can just as well use addiction to --

even an interpersonal relationship.
Now, in my background, especially going back to the '60s when I was doing psychopharmacological work and conditioning and things like that, we were very much interested in substances an how they affected people.
And I should say immediately that at that time, many of the substances that are illegal today were not illegal then. We just didn't know enough about them. So that I was very interested in finding out about this concept of why do people do things of any kind that are not in their best interest, that are addictive, even though they are self-destructive. So, that was my background in this area.
Q. What do you mean by psychopharmacological?
A. Well, pharmacological simply means chemicals, drugs that a person takes, an psychopharmacological

mean to limit it to those which have an influence on the mind or the brain or the brain on the mind.

Q. Now, is an addiction, from the psychopharmacological point of view and the psychological point of view something that can vary in strength or can be, you know, mild one day and strong another day?

MR. WALLACE: Objection to leading, Your Honor.

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THE COURT: Overruled as to leading, but the Court is becoming concerned that the witness is a treating physician, and one would think that he's going to be telling us about treatment at some point. Are we going to be getting to that soon?

MR. ACOSTA: Yes, sir.

THE COURT: Okay.

MR. ACOSTA: He -- I just want to make sure that when he gets to that point, that we're all talking about the same thing. Otherwise, I will have to -- we'll talk about the treatment and I will have to explain it -- have him explain it after.

THE COURT: Well, since we don't know what he's going to talk about, it's hard to have him explain that in a vacuum, but --

BY MR. ACOSTA:

Q. Well, let me ask you, did you treat Mr. Eastman for any addictions?

A. Yes, I did.

Q. Okay. So, can you explain to the jury, you know, whether an addiction is something that a person has control over it?

A. Yes, I could. I think I need to explain that addiction is an all or nothing premise. It's not

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something that you can have just a touch of. You do a certain thing until you get past a certain threshold an then you are addicted. An this has led to a lot of confusion, sometimes even between colleagues, who get confused with having a touch of something, getting more of it and being it.

Now in medicine, we have those things which follow the rule, like I like to call it a thermostat or a rheostat. Addiction follows the rule of a thermostat: Reach a temperature, it's on; another temperature, it's off. Your dimmer switch at home, that works like a rheostat. You can have nothing. You can have all the grades up to brightness until it's full.

You don't get a touch of pregnancy. You either are pregnant or you're not pregnant. You don't get a touch of diabetes. You have it or you don't have it. But there are thing that follow the rheostat. You can have a little pneumonia, you can have a little bit of a cold, a bad cold. But when it comes to addiction, it's a thermostat. You reach that point, that threshold, you are now addicted. And once you're addicted, you're addicted. It's all or nothing.

Q. Now, does that apply to cigarettes?

A. Oh, yes.

Q. Does it apply to alcohol?

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A. Yes.

Q. And how do you go about treating an addiction?
A. Which doesn't mean to say that everyone becomes addicted to alcohol. But if you are addicted, it applies as you either are or you're not. Oddly enough, there are people who drink alcohol in moderation or whatever and never get addicted. But that's not what we're talking about.
You asked me what addiction is, and I'm telling you if the medical diagnosis is achieved properly that a person under the DSM, whichever one you happen to be using, is addictive or dependent, then they are or they are not. And you have validating points to help you with this.
Q. Okay. Now, would you tell us what your course of treatment was with respect to John Eastman? First of all, did you do any objective testing of him or have any objective testing done?
A. Yeah. Now we're back to before about subjective and objective. I consider all that I do is objective because of my teachers, my books, my training. So that mental status examination an everything I do, I consider objective. Now, there are other things that could be done like certain psychometric tests, if that's what you are talking about. I consider them non -- the

truth of the matter is, they are not objective. They are really subjective because they are not exams that really tell you anything more than a good clinician should take. So, I did not do any type of psychometric testing.
Q. What is a psychometric test?
A. Well, for example, if you could do an MMPI, if you would do a Wechsler-Bellevue or any number of a thousand or thousands of tests that people do known as psychometric testing. I think they have a limited value in the hands of qualified psychologists who study how to do psychometric testing, but then it could only be to support what you are doing and help you understand it better. But you don't need it to validate anything. And in my practice, it's very, very rare that I would find that I need to do --
A good test, for example, would be a Rorschach, a good projective test. Sometimes I would employ that through a psychologist. But in his case, I did not need anything like that --
Q. All right?
A. -- for Mr. Eastman.
Q. Now, what did you -- did you assess Mr. Eastman at some point?
A. Yes, I did.

Q. And is the assessment the same thing as a diagnosis?
A. The assessment leads to a diagnosis.
Q. And did you ultimately form a diagnosis with respect to Mr. Eastman?
A. Yes, I did and I'm going to have to explain to you that my diagnosis includes things for which he did not originally come to me, but which were developed in the course of our therapy.
Q. All right.
A. Can I explain that, please?
Q. Yes.

A. Because otherwise, it would sound silly what I'm going to say. Mr. Eastman did not come to me for anything to do with cigarette smoking. He came to me because of the stressors that were affecting his performance at work, his social relations. I happened to, for my own personal reasons that I've taken almost -- you could say it's an oath as a psychiatrist, as a physician, that there are certain things when the patient comes to me, even if they didn't come to me for that, I should at least discuss it an bring it to their attention.

Those are three things that I had always dedicated myself to: One was if they smoked cigarettes,

two was if they used alcohol an three was if they were obese. And it's in that spirit that I discussed with him, as taking a history of any patient, every doctor does, we take a history of the substances that are toxic that they put in their body that they use. The most toxic, of course, being nicotine. Do you smoke? You have to know that. So, that's part of a routine examination of any patient.

But I always took it a step further an not only asked them and jot it down, but I then feel that because it's for a psychiatrist, clear evidence of a self-destructive type of behavior and we're trying to deal with the unconscious an see what the motivations are and how that might tie into their occupational problems, that we started to discuss this.

He was reluctant. He said, "I didn't come to you to talk about this." All my patients -- not all, but many, "I didn't come to you to talk about smoking. We're talking about overweight or smoking. Why are you wasting my time an money?" And I always have to say to them, "Look, it's just part of what we have to do. We have to talk about it."

It was in the course of developing our relationship as time went by that that came clear, that he was addicted to nicotine and that that became a part

of the diagnosis.

Q. And you mentioned that he didn't come to you for that purpose. First of all, how long was it that you treated him?

A. I treated him for a period of about six months.

Q. Okay.

A. On a weekly basis.

Q. On a weekly basis?

A. Yes.

Q. And when he came to you, did you have to get any commitment from him as to the amount of time that he would spend with you?

A. Yes. I tell every patient at the beginning that a course of therapy has certain limits. And depending on what their problem, is I try to give them an idea of what we're going to look for. So it's rare, if ever, that a patient would come in therapy for less than three months. A course of therapy will often be six to nine months, and I explain that to the patient.

Q. And at some point during the course of treatment, did Mr. Eastman express a conscious desire to try to quit smoking?

A. Oh, yes. We formed a -- what's known in psychiatry as a dyadic relationship. It was a good

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relationship between patient and doctor. We were getting somewhere. We were dealing with other matters, other feelings an thoughts about self-destructive behaviors. And at some point, we became allies in treating his addiction.

You know, at times he would actually get jittery when he would try. And he -- you know, I laid out a course of therapy for what he had to do, how he had -- how much he was smoking, he should start cutting down, he would get below certain levels, and we worked on that.

Q. Was that an accepted method at that time? You are describing cutting down. Why -- first of all, why would you do it in a step down way?

A. I wouldn't. Actually, just as in alcohol, I believe and I think the finest minds in the area of toxicology believe that the only answer is total abstinence. But so very few people can do that. And you don't want to shock a patient and force them to do something they don't want to do, even though it probably wouldn't be as bad as they thought. So usually what you try to do is what the patient will allow you to do, an you're grateful that you're at least working on the problem. And in most cases an in this case, as I recall, the best we could do was to try to strengthen

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the idea of -- especially because, you know, people have the idea that smoking relaxes them and it becomes that kind of habit in the mind, even though it actually makes them more jittery. So, it's a contradiction. But nonetheless, if they believe that and you want to take it away totally, it might lead to great resistance in therapy.

Q. Did he cooperate with you?

A. In the beginning, he cooperated very nicely an we were moving along. As I told you, I thought we would last six to nine months in therapy. He prematurely terminated his therapy, by the way. He did not successfully complete the course of therapy.

Q. After six months?

A. After six months, yes.

As a matter of fact, as I recall looking at the notes, what we call a resistance to therapy, which is, again, unconscious, the patient is not aware of it. But for example, you find the patient calling to cancel appointments. So when they come the next time, you say, well, I wonder if you really think the reason you couldn't find 45 minutes during that week was so important. Oh, no, it really happened. I couldn't -- see, those are all unconscious excuses for why, but you as a therapist begin to understand you're losing the

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patient. They are beginning to drift away on an unconscious level. They are not even aware.

Now, you might hypothesize the reason is it's getting too uncomfortable, too hot, they don't want to give up or other things are happening which stress them out. But whatever it is, it's a qualified therapist, you need to take all this information in, work with it, and try to explain to the patient and make that which

was unconscious, conscious.
Q. Now, did the subject of alcohol come up between you and Mr. Eastman?
A. Yes, but never as a major issue.
Q. Did you make any assessment or diagnosis that related to alcohol use?
A. No, alcohol was not a problem.

Q. Related to alcohol use?
A. No. Alcohol was no problem.
Q. Now, can you tell the jury just in summary form, perhaps, what your -- the course of treatment was for Mr. Eastman and what you attempted to do for him?
A. What often happens is by the time 12 weeks go by and you have established a relationship with the patient, you are working well together, he has confidence in you and begins to believe in some of the

principles of what you are trying to teach him.
You know the word doctor actually comes from the Latin word dosseri, which means to teach. It's not just to treat a patient, but it's to teach a patient. And nowhere greater than in psychiatry is the relationship where you are teaching the patient the things they didn't know and give them the tools to be able to improve themselves.
So by the time 12 weeks went by we were solidly working as a team in the therapy. And I really felt that we were going to get somewhere, that we were starting to deal with cutting down, we were starting to deal with other problems. And suddenly, maybe because of extraneous things or whatever, I began to see the resistances with the capital R, the unconscious resistance to therapy appear. And I was trying to interpret them to the patient. And I felt more and more I'm losing him. Until finally at one point we had to terminate the therapy because it really wasn't succeeding.
But if it had been or if he was -- I don't want to say he wasn't cooperative, but on an unconscious level he couldn't muster it, he left without being helped in that area.
Q. Now, did he -- when you say on an unconscious

level, he couldn't muster it, what do you mean by that?
A. Could you repeat that, I missed that.
Q. You said on an unconscious level he couldn't muster it. I don't know exactly --
A. Yeah, what I meant to say is that the goal between the doctor and the patient was to take that which was unconscious, that the person was self-destructive about, that they're doing, that they formerly were unaware of and to make it more aware, more aware, more aware.
Q. And did you make him aware that the smoking was self-destructive?
A. At one point I thought that we had brought it up to a level of awareness that he was working with me, and I had a hope -- because we were cutting down on it. But you do have to understand that there was this problem of withdrawal. And as he tried cutting down, he needed the support of the therapy to help him overcome the irritability, the anger. And then there is this

hodgepodge of is it only because he's cutting down the cigarettes that he now is having problem with his main reason for coming, which was his professional life. And that was things that were working together simultaneous, which I believe brought him under great stress so he couldn't muster, as I say, maybe he couldn't bring up

enough to help his own illness to be less self-destructive.

Q. Was it for lack of trying?

A. No. No, I think he tried very hard.

MR. ACOSTA: I think that's all the questions I have.

THE COURT: All right. Cross-examination.

CROSS-EXAMINATION

BY MR. WALLACE

Q. Good morning, Dr. Groff.

A. Good morning, sir.

Q. David Wallace, we met in the elevator this morning.

A. Yes.

Q. Good to see you again, sir.

All right. Now, you are a psychiatrist; right?

A. Yes, sir.

Q. And that's -- or actually you're a psychoanalyst, is your specialty as a psychiatrist; correct?

A. No. I have been psychoanalyzed myself, and I practice psychoanalytically oriented psychotherapy. But the term psychoanalyst is a protected term for those who have gone to an institute of psychoanalysis and carry a

card to such. I am not a psychoanalyst.

Q. That will save us some time. Thank you very much?

A. You are welcome.

Q. All right. Let's talk a little bit about your practice, doctor. First of all, as I took your testimony, your psychiatric practice is exclusively private at this point in your career?

A. Yes.

Q. And why don't you tell us, please, what that means?

A. That patients come to me as a self-employed person. I have no employer.

Q. And how long have you been in private practice yourself, Dr. Groff?

A. Since 1971.

Q. Do you work out of your home?

A. No, no. I have an office.

Q. As part of your practice, do you subscribe -- or prescribe psychiatric medications on occasion as appropriate?

A. Yes.

Q. Is there a certain profile for the patients that you typically see in your practice? Do they tend to have certain conditions or problems that would help

us understand your particular expertise?

A. No. I could rather describe it as eclectic.

Q. Which means very, very --

A. Very broad -- yes, a broad spectrum of

patients.
Q. And how much -- what percentage of your practice, Dr. Groff is related to the treatment of substance abuse?
A. Throughout the years since 1971, I would say with both adults and adolescents maybe 10, 15 percent.
Q. So it's a part of your practice, but it's a smaller part of your practice --
A. Yes.
Q. -- treatment of substance abuse problems?
A. I don't have exact statistics, but off the top of my head had to guess, I would say something like that.
Q. All right. Have you ever run a smoking cessation clinic --
A. No.
Q. -- Dr. Groff? And that's -- I think the way I took your testimony was that it sounded to me as if you have patients who will come to you with stressors in their life, serious conditions, or neuroses or anxieties which they might be struggling and if they happen to be

smoking, you have made it your practice or if they happen to be abusing alcohol or they happen to be obese, at some point inject that into the therapy and help make the patient conscious of that part of their life, is that what you are saying?
A. Well, actually more than that. At the initial evaluation, at the very beginning, as ever doctor will take a history of whatever toxic substances a person is taking into their body or whatever they're doing, we learn -- and that's -- going back to medical school, to always ask about tobacco, always ask about alcohol, and obesity became very important in the '50s.
So as part of that, when I would become aware of a patient who had excesses in any one of these three areas, even though that is not what they came to me for, they may have come to me for marriage counseling. If I found that was a part of it, I would then explain to them and hope that they wouldn't be upset by that, but I would like to discuss that as a part of their behavior because I felt that that was a -- an unconscious thing that is going on that if they would look at that as well, it might help them to understand more of the things for which they think they're coming.
Q. Sure. And then these sorts of things that as an experienced trained professional that you try to

elicit from your patients, the things that they might not be aware of. For instance, like they smoke cigarettes or they drink alcohol or that they're obese. When you observe those -- that information, do you try to put that into your notes as part of the initial assessment, some of your objective findings and observations of the patient early on in your treatment?
A. Well, it's so routine that I might just not even bother to write it down, unless it was really something very serious.
Q. Now, how many --
A. If the person came me for that, for example --
Q. Right.
A. Then that might be different.
Q. Can you tell me, Dr. Groff how much patients

you have treated in your 30, 31 years or so of practice that came to you without realizing they smoked cigarettes?
A. I don't think I ever said what you just said.
Q. So the answer is no, you have never had anyone come to you who was unaware of the fact that they smoked cigarettes?
A. I can't hardly believe that somebody doesn't know they're smoking cigarettes. I never said a person doesn't know they're smoking cigarettes. I said they're

not aware of the destructiveness of the smoking of the cigarettes and rationalize about it and continue to do it despite it not being a good thing for them, but of course they know they're doing it.
Q. And of course based on what you just said, doctor, they know it's bad for them, otherwise why would they be rationalizing it; correct?
A. This is hard to say. I would have to see which particular case and which person we are discussing and if I had a particular case, I might be able to evaluate that. But I don't think I can make a blanket statement.
Q. I -- you know -- but generally, rationalization is, as I understood what you explained was, it's this defense mechanism that we have as human beings that allows us to deal with information that might be creating conflict and stress in our mind about our behavior; correct?
A. Correct, yes.
Q. And I guess you can correct me if I'm wrong, but it seems to me that in order to engage that coping mechanism or that rationalization process, we have to have as individuals some degree of conflict originally about a particular behavior; right?
A. No.

Q. No?
A. Why would you postulate that?
Q. Well, why don't you help us understand why people rationalize then, or is it only certain types of people who rationalize?
A. No, I think anyone can rationalize.
Q. Okay. And why would a person typically feel the need, consciously or unconsciously, to rationalize something?
A. Well the rationalizations as I use it it can only be unconsciously because that's the mental mechanism of defense.
Q. Okay. Now as you --
A. Now rationalization -- excuse me.
Q. You go ahead and finish.
A. Rationalization is probably one of the healthier mental mechanisms of defense. We all use it at various times. I think if you recall earlier I talked about denial, which is one of the more serious mental mechanisms of defense. It's probably like the same as rationalization, but very much worse. People use mental mechanisms of defense to avoid dealing with something that makes them uncomfortable. They don't want to deal with it.
Q. Right. They're doing something that someone

might be telling them is bad for their health and they shouldn't do, and that's where the rationalization comes from; right?

A. Yes, it could happen that way.

Q. And all you're telling us is that although psychiatrists are aware of this and know about it and can come and talk and explain it, the people who are doing the rationalization, they're unaware of it. They don't know it. Is that your testimony, Dr. Groff?

A. No. I think there might be psychiatrists who also have rationalizations and there may even be psychiatrists who smoke. And despite being confronted with all the obvious things would still make their own rationalizations and continue doing the self-destructive things. So that's possible as well.

Q. Sure, but I --

A. No one is free of using this mental mechanism of defense.

Q. Right. As human beings we all have the ability to rationalize; correct?

A. Well, not all human beings, but let's say most normal human beings.

Q. Around you're not telling the ladies and gentlemen of the jury that only psychiatrists understand the fact that rationalization occurs?

A. Oh, no.

Q. Okay. The -- as an individual, I'm capable or let's say Mr. Eastman, he's -- I think he's the best example. He's capable of understanding that he might be rationalizing his behavior, coping with behavior that's creating discomfort for him; correct?

A. No, that's incorrect. Let me explain to you.

Q. Please. Thank you.

A. If you understand what the word rationalization means, and I will try to define it for you one more time. It is a mental mechanism of defense that resides in the unconscious. Mr. Eastman could very well evaluate you and your rationalizations, but he could not possibly by definition understand his own rationalizations because they're unconscious, he is not aware of them.

Q. But, doctor --

A. But did you follow what I was saying?

Q. Absolutely. Thank you. I'm clear.

I mean, I could be diagnosed with cancer, for instance, and I'm a lawyer, I'm not an oncologist or anything else in the medical profession, but when my doctor says; David, I'm sorry, you have cancer. I can understand that, can't I? I can hear that and understand that, even though --

A. Well --

Q. Hold on, I have to finish my question.

A. Okay.

Q. Even though I might not be able to explain to my doctor what cancer is, I can understand that I have cancer; right?

A. Is that your question?

Q. Yes.

A. Good. You're having a problem with this, and I have to explain this to you. The unconscious means that which we are unaware of. In the example you just

gave, if your doctor tells you that you have cancer, you can understand that. You're aware of that. But if you were to say just for example -- I'm inventing an example now to help you understand. If you were to then say to your doctor, "so I'm still taking my trip this June to Europe and taking the kids and all that." And he just got finished telling you that you got three weeks to live, then I think you would be using a rationalization, which he would recognize from what you said that you're not aware of it.

Q. Sure.

A. But he would be aware of it.

Q. Right, but --

A. Do you follow me now?

1944

Q. I have been with you from the word go, sir. Why don't you tell us based upon the six months or so that you spent treating this man, Mr. Eastman, whether you came to the opinion that he was unaware of the fact that he smoked cigarettes, is that your testimony?

A. Went a little fast, but here is the way I think it happened. In the beginning he didn't come to me for cigarette smoking. I brought it to his attention, so he was really nor consciously nor unconsciously aware of the fact that the cigarette smoking would be an issue.

At my request when we started to expose it and discuss it on a conscious level, we began through the techniques of psychoanalytically oriented psychotherapy to try to help him to explore his unconscious.

As that process continued, and as that developed, he began to little by little gain more insights into not only the fact that he was smoking an awful lot and didn't seem to be able to deal with it and didn't want to deal with it, but began to see the self-destructive qualities of that and we began to work on it.

So somewhere after a few months it would be okay to say he started to now become aware of something which he formerly was unaware of.

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Q. All right. So to the extent he was unaware of it, he was unconscious of it, he didn't want to think about it, he didn't want to talk about it, you as an experienced trained medical professional in psychiatry helped him to come to the realization that he smoked cigarettes; correct?

A. And more than that, also that they were not good for him and they were destructive to him and even influencing the reason for which he did come to me in a negative way.

MR. WALLACE: Your Honor, may I have the clerk mark this.

THE COURT: All right.

MR. WALLACE: Please, as DX 11,000 for identification.

(Thereupon, Defendant's Exhibit 11,000 was marked for identification.)

BY MR. WALLACE

Q. Dr. Groff, what I'm going to do -- actually, may I please borrow your stapler, madam clerk -- is hand you your records from your treatment of Mr. Eastman. It's been marked DX 11,000. And what I'm going to do is

there are parts of these records, Dr. Groff that contain some pretty sensitive private information, so I don't want to display all of that information to the jury.

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But obviously it's not private to you because you treated him. And so there will be occasions in my questioning where I'm going to have you look at certain entries to tell me whether information appears there, okay. But I don't want to disclose everything in this man's records because a lot of it is private to the jury. Okay. But we will be displaying parts of it.

What I would like to do is first go through -- you have got your notes of your treatment of Mr. Eastman, and first I would like to ask you whether those notes are the -- the notes that you typically prepare when you see a patient like Mr. Eastman?

A. I don't think I can say that they're typical. I think that I have other cases where notes are more voluminous. I have other cases where note are much more scanty. It just depends on the circumstances.

Q. Okay. So -- and as you have indicated, your practice has been varied over the years so would the notes that you have there, the two pages of notes for your treatment of Mr. Eastman be typical of some of the patients that you see where the records are somewhat scanty?

A. Yes, sir.

Q. Not all of your patients -- you don't develop voluminous records for all of your patients; correct?

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A. Yes, that's correct. Let me modify that. It just depends on why they came to me. For example, if I knew at the outset that I was going to have to write a particular report if the patient was referred to me from another physician for another reason. I might treat it differently getting ready to put a report together at that very moment so that at the end of that it could have a different structure. Also there are times when a patients only sent for an evaluation.

So depending on why the patient came. But you would be correct in saying if a patient came such as Mr. Eastman without any special reason for it leading to making a report or something, I might do something like this.

Q. And I would also be correct to say that Mr. Eastman based on your testimony did not come to you for help in quitting smoking; correct?

A. That's correct.

Q. All right. I think as you put it, he came to you for -- to help himself manage some of the other stressors he was experiencing in life, primarily occupationally; correct?

A. Correct.

Q. As well as based on my review of the records stressors in issues which she was dealing based on his

1948

relationships with people in his life; correct?

A. Actually I think the primary thing was his occupation. I think it had to do more with his television shows and television business and things like that. Because I know for a fact that that stressed him out tremendously. He had -- something for example, that stood out in my mind was that he was very busy and

concerned with starting a television show here at the pier in St. Petersburg. And that thing hit a snag and fell through and that really devastated him. That really hurt him a great deal. And I think the reasons for which he came to me had more to do with his occupational life rather than his socially personal life. Although that was discussed.

MR. WALLACE: Can we see the first slide, please.

Q. That's a copy of the entirety of your medical records or treatment of Mr. Eastman; right, Dr. Groff?

A. Yes.

Q. And that's a copy of what you're holding in your hand; correct, sir?

A. Yes.

Q. So last night when I was looking at these -- well, I made a couple observations. And I just want to -- you can take my word for some of these. You got

the records. According to the records the first time you saw Mr. Eastman was January 11st, 1980; correct?

A. That is correct.

Q. Some 23 years ago?

A. Yes.

Q. The last time you saw Mr. Eastman was for this session right here, July 9th, 1980; correct, that last one? Next the to the last entry?

A. Yes.

Q. In your records. Because the last appointment you made Mr. Eastman didn't make, did he?

A. Correct.

Q. He was a no show. Can you help us understand -- will you show me the no show slide, please. What I have done is, as I indicated, you saw him according to your records over a 6-month period from January 11th to early -- I'm sorry, January to early July of 1980; correct?

A. January 11 of '80 through January 16 when he did not appear for that last appointment.

Q. July 16.

A. Excuse me, July. I apologize.

Q. All right. Now, you can either take my word for it, sir, or you can do it yourself. But if you add up all the appointments with Mr. Eastman it adds up to

26 appointments.

A. Yes. I have it noted as 26 scheduled appointments and four that he didn't show up for.

Q. And as a no show as in he -- he didn't call you in advance, because what I found right here, 1, 2, 3, 4, 5 -- we have got six no shows -- I'm sorry, let's do it another way. This is the one where he didn't show and then treatment was terminated. This is the last one, July 16th; correct?

A. Yeah. 1, 2, 3, and 4/16.

Q. So then we have got January -- February 27th, 1980, John Eastman C/A is canceled appointment; right?

A. Right.

Q. And he canceled the appointment according to your notes because he had a business meeting; correct?

A. Correct.

Q. April 16 he is late, which you note on your records. And then he doesn't show at all, which is N

period S period; right?
A. Right.
Q. And then it says -- your notes indicate that it got, quote, seduced, closed quote. Do you have any recollection at this point what got seduced had to do with Mr. Eastman's inability to make his appointment with you?

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A. Yes. I believe what he said to me when I spoke to him on the phone was that something took him away from keeping the session. What that was exactly, I couldn't tell you.
Q. All right. And just to help us as we go through these records in a little more detail, when you have something in quotes in your record, I took that to mean it was something Mr. Eastman told you; is that accurate?
A. Not always, but I think --
Q. Or paraphrase?
A. Not always, but I think in this case it would be. Seduced in itself is in quotes. So it wouldn't necessarily mean that he said it, but it might mean that it was some kind of description that he made as to why he was unable to show.
Q. Sure. I mean that's why --
A. Here's an example of the rationalization.
Q. Yes. Well, sir, we've already moved on. Okay. We're not talking about rationalization anymore. We are talking about Mr. Eastman not showing up for his appointment on April 16th because he got, quote, seduced. And I'm just trying to understand how the word seduced would get into your records.
The fact that it's in quotes led me to believe

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that it's something either directly verbatim that he said or something close to what he said, and that's all I'm trying to get at.
A. I believe that sounds like that's likely.
Q. And then the third cancellation is -- this third cancellation or no show is May 21st. And it says; January called to C slash A, cancel appointment; correct?
A. Yes, that's what it says.
Q. And then it indicates that you had a T slash C with John, which I took to mean a telephone conversation?
A. Correct. I would say that's what that means.
Q. All right.
A. The logical order of that would be I'm expecting him on 5/21. I get a phone call from Jan who says he's going to cancel. And then afterwards he calls me on the phone and I have a discussion with him.
Q. All right. And according to this entry for May 21st, all we know is that you had a conversation with him. We don't know what that conversation was about. We don't know whether it was a session or whether he just called to apologize for cancelling the appointment; correct?
A. Yes.

1953

Q. And then just so we understand how this -- these other things happen, like where it says late, late, late -- I take it that means that you're waiting

for a scheduled appointment. It's past the time the hour was to begin. Mr. Eastman was not there. You know late. You go about some of your business perhaps. He never shows up, at which point you write; no show, or N period S period?

A. Yes.

Q. What we have here is you saw Mr. Eastman. He had 26 appointments with you; correct?

A. Yes.

Q. We counted all those up. And we have one, two, three, four, five appointments that he either cancels or doesn't show up for; correct?

A. Yes.

Q. So we are down to 21 appointments, right. Of impacts -- 21 sessions that you had with him.

A. Yes.

Q. And then the last session was July 16th, and he doesn't show up for that one; right?

A. Yes.

Q. And so you had -- you ended up out of 26 scheduled appointments that Mr. Eastman made with you, the two of you were actually in session only 20 times

over six months; correct?

A. This is correct.

Q. Now, if you could help me understand this, I have struggled with this. Because it says; late no show. This is the entry of July 16th. Refused -- in parentheses -- refused CBG, close paren, arrow, terminate, double backslash. What does that mean?

A. That actually says call back six.

Q. Call back six?

A. Yes.

Q. All right. What does; refused, call back six mean?

A. A call back six was actually -- he lived out of the area, and it's a long distance call, and I placed a call to him, and the operator said that whoever it is you tried to call refused to accept the call.

And as you could see as you so accurately pointed out, that in the latter stages of our therapy he began to show increasingly greater and greater resistance to the therapy. So this indicated to me that that was the final point, and I had explained to him earlier, so there at that point I felt professionally and medically okay with saying we might as well end the therapy.

Q. Right. And --

A. Which we did.

Q. I'm sorry, doctor?

A. Which we did.

Q. You terminated it or Mr. Eastman did?

A. Mutually. You could see we discussed that and said, look, you're showing up less and less now, I think there is unconscious motivations, things you don't want to deal with. This therapy is not going to where I would have hoped it would go. And I personally felt the therapy had failed.

Q. Is there anything that happens in your office with a patient that's conscious, Dr. Groff? Or is everything unconscious?

A. Wow. No, I think most everything that happens

is conscious, sir.
MR. WALLACE: Can we have the first slide again, please. Excuse me for crossing this.
Q. These are some of the entries I was telling you. For instance, I don't want to go into these in detail if people can't read them, but I want to address the point, or have you explain the point better where you reached the point of termination, this mutual decision that therapy would not continue.
And what I observed last night in reviewing your records is it kind of started strong and hard and

the two of you guys are talking about a lot of things. A lot of things being put on the table and he is showing up for his appointments for the first few months; correct?
A. Yes.
Q. And that's according to your notes, which has been marked, DX 11,000; correct?
A. Yes.
Q. All right. And then what happens is we've got his first cancellation here in February, late February, some two months into the treatment because of a business meeting; right?
A. Yes.
Q. Right up here. You continue to see each other through March. You have your first session on April 9th, and then a pattern begins to emerge in April; correct, April 16th; late, no show, got seduced.
And then through May -- basically you got Jan calls to cancel, and then late -- no show, late no show. And what I understood you to be saying was through the period May and June, the relationship -- or at least Mr. Eastman's commitment, his motivation to go through therapy consciously or unconsciously seemed to wane somewhat; right?
A. Well, I think we should say whether it's

consciously or unconsciously, because I think it's very important.
Q. Was it conscious or unconscious?
A. For example, on a session that you mentioned earlier -- early on I began to say that he is showing resistance to therapy.
Q. Where do you say that, sir?
A. On 2/27/80 where John Eastman canceled the first time and he had a business meeting.
Q. Right.
A. The very next session, 3/5, not that it's important that I wrote it, but I did actually write it, it says; discussed resistance to therapy. That's what those symbols mean.
Q. Why don't you help me out a minute. Your Honor, may I get right in the box with the doctor?
A. Must you?
Q. Well, I will stay back.
A. Why don't you go over there and read it from there.
Q. I'm not consciously aware of a biting tendency?
A. All right. I will put it over there.
Q. You do that. Which one do you want to show me, sir?

A. You see.
Q. Did I not shower long enough today?
A. No, it's not that -- 2/27/80, John Eastman cancel, had business meeting. You see 3/5.
Q. Right.
A. Discussed resistance. That's symbol for resistance.
Q. Okay. That's one I couldn't make out.
A. It's cryptic. Discussed resistance.
Q. Right.
A. Was too open. Didn't like what he sees. And it says; Susan Boots.
Q. Okay. That's what we don't want to go into.
A. You see early on the first time he didn't show up I started to help interpret his unconscious with him and say; look, you don't want to deal with things on a conscious level. It's getting too hot for you.
Q. Right.
A. And that's maybe why you didn't show up.
Q. And what's your recollection of what Mr. Eastman's reaction was to your confronting him with the observation that he seemed to be resisting treatment?
A. Well, this is always a dramatic moment in therapy where you have to develop an alliance.

Q. Right.
A. So actually I welcome that early on that a person has unconscious things that are driving them and you have your ability then to sit down in the therapy and explain to them. And this is what the whole thing is about.
Because if you can do that, if you can get them to understand one part about their unconscious you might get them to understand about their addiction and get them to understand other things that are truly beyond their knowledge motivating them and moving them. So that is a dramatic moment for a therapist where you can interpret the unconscious.
Q. I appreciate that. I must have been unclear so I'm going to ask the question again. What was Mr. Eastman's reaction when you confronted him with your thought, your observations that he was resisting treatment?
A. Well, obviously this is 24 years ago.
Q. Right.
A. But the fact that he continued in therapy and our relationship only got better is what Dr. Freud explained and what we learned as psychotherapists that that indicates that the resistance is being reduced. So I could only extrapolate from this that it had a

positive meaning and that he was then willing to work further and longer with me, which he did.
Q. Right. Well, I guess then what you're saying is you were unable to observe any conscious reaction on his part to your observation that he seemed to be resisting therapy, is that what you're saying?
A. What I'm saying is that, you know, it's 24 years ago, and to really try to remember exactly how he responded, you know, as you and I are responding right now, is truly very difficult.

However, to extrapolate from the relationship of what's most important, how it moves on from there I think speaks for itself.

Q. All right. So the answer then to my question is in layman's terms about your recollection of his reaction is; I don't know, I don't remember; right? Would that be accurate to the say?

A. Yes. I have no independent recollection of what he looked like or what he said consciously.

Q. Where were you contacted by Mr. Acosta to testify in this case?

A. I believe either by a letter or maybe a telephone call. I can't recall.

Q. Are you charging Mr. Acosta for your time here today?

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A. No, I'm not.

Q. What's your normal -- do you give depositions sometimes in cases like this?

A. Oh, yes, I do.

Q. And what's your normal rate for sitting down to talk with lawyers about patients that you may have treated who are in litigation?

A. I haven't really gotten involved in the last many years about this, but when I was doing it, my rate was $350 an hour. And very often I would allow the judge in a case to determine what ought to be the remuneration in a particular case. And then when I was doing it a lot more, that's oh, 15, 20 years ago, I actually had a fee schedule where I list very carefully what had to happen and how it had to be paid and things like that.

Q. Right. Excuse me for turning my back?

So you haven't really done it in a while?

A. No, I haven't been doing this kind of work in the last, oh, 5 to 10 years, very little.

Q. But certainly there has been inflation since the day you were charging $300 an hour to sit and talk with lawyers; right?

A. Unfortunately from what I hear I recall the judge saying last time when I had a fee he asked the

1962

lawyer what do you charge per hour. And he said; well, this doctor has more education than you, so he charged a higher fee. I think the fees have actually gone down, I don't know.

Q. So a fair compensation for your time, let's say I want today sit down and talk to you for an hour. I want to do that about a case, what would be fair compensation? What would be fair for me to have to pay you to sit and talk to you, take an hour of your time?

A. $350 an hour.

Q. All right. Is it true, Dr. Groff when the defendants in this case expressed an interest to taking your deposition you told us that your charge was $1000 an hour?

A. No, that's not true.

Q. Let's take a look at -- do you communicate by E-mail, Dr. Groff?

A. Sometimes.

Q. All right. This is an E-mail that -- well, let's see --

A. Yeah, minimum fee for deposition, 1500.

Usually I would charge 2500. But I thought, well, I haven't done it for a while. My minimum fee would be 1500, which includes one hour minimum to one and a half hours maximum. So now that would be at the rate of 1

and a half hours. And then I said, any additional time beyond 1 and a half hours would be $500 an hour. This is not just face to face. This is depositions and in-court testimony from when I had a fee schedule in the past.

Q. Well, actually --

A. And also I believe --

THE COURT: Just a minute, sir.

BY MR. WALLACE

Q. Dr. Groff, I'm sorry, you said after the minimum payment to you of $1,500, you said that your charge thereafter would be $500 per hour. But in fact what you wrote was that your charge would be $500 per half hour?

A. I misspoke. It should be 500 per half hour. If it went beyond the 1 and a half hours another half hour would be $500. That's what I would ask.

Q. And this is -- I mean, you don't deny this came from your office, do you?

A. Oh, no, I sent that.

Q. You sent it to April -- Ms. April George who appears to be a paralegal at Mr. Acosta's office?

A. Yes.

Q. Okay. All right. Let's talk about John Eastman a little bit more. Did you have a personal

relationship with Mr. Eastman before he came to you for treatment?

A. No, not before.

Q. All right. Now, Mr -- there has been some testimony in this case previously by Mr. Eastman that the two of you got together and helped bring a very famous therapist -- I think he's a therapist -- to the Tampa area, a gentleman by the name of Dr. Timothy Leary. Is that your recollection as well, sir?

A. Yes.

Q. Okay. Can you tell us what Dr. Timothy Leary is or was?

A. Dr. Timothy Leary was a psychologist of quite some fame at Harvard who had written a very large tone on transactional psychology which is being still used today. This man did a lot of research and ultimately got involved in using psychodynamic drugs. And I think became very infamous, rather than famous, for his use of LSD, at least in the press, ultimately even got arrested, was out of the country, came back to the country, wrote many, many books on the psychedelic experience and was considered quite the guru of understanding drugs and behavior.

And at some point in the '70s, I guess it was -- well, actually let me backtrack. When I was

working for the space program, I was a research consultant for NASA, and as part of my work for them, I once paid a visit to this place that he and another -- a couple of psychologists, one was Dick Albert and one another one was Ralph Metzner. And I went there to interview them. Unfortunately he wasn't there, but the

other two were. To make a long story short, I was very interested in the '60s in that area of work.

Q. LSD?

A. I beg your pardon.

Q. LSD?

A. Oh, yes, LSD, mescaline.

Q. I'm sorry. What is mescaline, doctor?

THE COURT: I think we are wandering here a little bit, aren't we.

MR. WALLACE: Your Honor, I will move on.

THE COURT: Okay.

BY MR. WALLACE

Q. When Mr. Acosta contacted you, what did he tell you this case was about?

A. When Mr. Acosta contacted me. Actually I think I sent that -- when I received the subpoena for records that I sent to a Nancy Faggianelli, I believe.

Q. Yes, sir.

A. I discussed with her my fees. She wanted to

set me down for deposition, it was all arranged. And I didn't even know Mr. Acosta at that time, but only thought that when I looked at the style of the subpoena that it ought to go to these other people. So I just faxed a copy over to them.

And my only contacts were with that firm and then we had this problem where first they set me for deposition and they said it was too much money. And I said whatever you want to charge was okay with me. We set the deposition again. The next thing it was cancelled.

At that point I believe I heard either by telephone or from Mr. Acosta's office, one way or another, but I don't think anybody told me what the case was about at that point.

Q. All right. Was -- did there come a time when Mr. Acosta or someone working for him spoke to you and told you what this case was about?

A. Yes. No, not actually in those words. I think how it came about was there was this little up and back about whether I would or would not be in deposition. And then I received a package containing a little document that showed my transcribed notes with a little statement about it. And in that I came to recognize that there was this lawsuit and what it had to

deal with because it was all full of that thing about the tobacco smoking and nicotine. I think that's how I became aware of it.

Q. I'm sorry. What was full of tobacco?

A. This document that I believe was done by Dr. Kaplan. He had read my report and I believe Mr. Acosta's office sent it to me so I could be aware of what he said about my report.

Q. So you had read the report prepared by Dr. Kaplan, the Defendant's expert in this case?

A. I have, yes.

Q. And do you have any criticism of that report in terms of its professionalism or comprehensiveness?

A. No. I think it's a very well done report. And I think there are some things I would take issue with, but certainly it sounded like a very airenditen (phonetic) report.

Q. And airenditen (phonetic) means what, sir?
A. Studied, intelligent, well done from an intellectual perspective.
Q. Okay. What I want to do now --
A. I don't know Dr. Kaplan, by the way.
Q. You don't know him even by reputation?
A. I have never heard of him.
Q. But based upon the report that he's prepared

1968

in this case which you reviewed, you have no reason to question his credentials or his affiliates as a psychiatrist; correct?
MR. ACOSTA: Object to the form of that.
THE COURT: Sustained.
BY MR. WALLACE
Q. Here's an example -- what I would like you to do, Dr. Groff, please, is take a look at the first two sessions. Your notes of your first two sessions, January 11th and I think -- and I think it's January 15th of 1980. I was unable to make that date out. What I would like you to do, please, is to review those two sessions -- your notes of those two sessions, read them to yourself, and tell me whether they mention cigarette smoking, tobacco or nicotine or addiction.
THE COURT: Are we getting close to the conclusion?
MR. WALLACE: We could take a break right after this, Your Honor.
THE COURT: Okay.
A. No, they do not.
Q. Okay. The first two times you met with Mr. Eastman there was no discussion of cigarette smoking?
A. No, I cannot say that.

1969

Q. Your notes do not -- you're right. Let me re-ask the question. According to -- your notes do not contain any memorialization of the fact that the two of you discussed cigarette smoking in either of the first two sessions; correct?
A. That's correct.
MR. WALLACE: Your Honor, we can take a break now.
THE COURT: All right. We will take a 15-minute recess.
THE BAILIFF: All rise.
(A recess was taken, after which the following proceedings were had:)
(10:50 a.m.)
THE BAILIFF: All rise. Court is now back in session.
THE COURT: Are we ready to continue?
MR. WALLACE: Yes, Your Honor.
THE COURT: Let's have the jury back.
THE BAILIFF: Yes, Your Honor.
(The following took place in the presence and hearing of the jury.)
THE BAILIFF: Jury is in the jury box seated, Your Honor.
THE COURT: Thank you. Let's continue.

1970

MR. WALLACE: If we could have the slide, please, for February 12th. If -- enlarge the

blowout entry, please. Can we magnify it a little bit or no?
BY MR. WALLACE:
Q. I want to just talk about one entry. This is from your notes, Dr. Groff.
A. Yes.
Q. Take your time.
Okay. The entry for February 12th is the one that we have displayed on the screen here. Are you able to read your notes or the screen?
A. Yes.
Q. All right. One of the things I want to talk about here is -- and like a number of entries, there is a number of references in your sessions to a woman named Jan, J-A-N; correct?
A. Yes.
Q. And this one here -- I can't make this out, the first entry. It looks like "HC to Jan."?
A. No, it's H -- "He and Jan always paranoid."
Q. Okay. So "He and Jan, he told you that he and this woman named Jan were always paranoid about something?
A. And then there is an arrow.

Q. "healthy skepticism."?
A. Yeah. And I put that in quotation marks, I believe.
Q. So that would represent something that Mr. Eastman said to you; correct?
A. No, I think it's what I said to him; that I may have been correcting his use of the word "paranoid," which usually has a more ominous meaning, to mean that they are not paranoid, which might be the utterings of sick people, but they are really just healthfully skeptical.
Q. And it's healthy in life -- it's a healthy part of a human condition to be skeptical or questioning about some things; correct?
A. Absolutely.
Q. And that appears to be what?
A. Well, and I say with the arrow "Is not abnormal. Is a question of degree."
Q. And that's what it says over here, that "healthy skepticism is not abnormal. It's a question of degree"; correct?
A. Correct.
Q. And the only other thing I want to talk about -- two other things is right here. First of all, in quotes it says "John Eastman is great." Is that

something that you said in the session or something that Mr. Eastman would have said to you in the session?
A. I have no idea. It could even be something that something else said and we were just quoting it and saying -- like something from his TV show or maybe an admirer might have said that. I have no idea.
Q. Let's assume -- let's hypothesize that Mr. Eastman said it to you. What diagnosis do you typically make in patients who refer to themselves in the third person as being great, Dr. Groff?
A. Well, although I don't know who said it, I can guarantee you he didn't say it.
Q. I'm sorry. You can guarantee us that did not

say it?
A. That he did not say that. He wouldn't say a thing like that.
Q. How do you know that, sir?
A. Not only knowing him then, but I know him now; and that would be not the kind of statement that a person like John Eastman would ever make.
Q. How many times have you seen John Eastman since he terminated -- the two of you mutually terminated your patient-doctor relationship in 1980?
A. Early on we saw each other much more. I believe I was even a guest on his TV show. I was a

1973

guest on his radio show. There was a time when I had my own radio show on the same network, I think it was. And then as the years went by, I guess because I had been traveling much more nationally and internationally, we have kind of gotten away from each other. And we have other mutual friends, things that would have caused our paths to cross. So I would say in more recent years we haven't seen each other but sporadically. And we are still friends, and I'm still a great admirer.
Q. When is the last time prior to here in court this morning that you had seen Mr. Eastman?
A. Oh, maybe a few weeks ago.
Q. And what was that occasion, sir?
A. As I say, from time to time, I would pass by, if I were up in the north of Florida and coming down. Now that I found out where he lived, I would pass by and say "Hello." And I really didn't have any idea about this lawsuit. We were talking about, you know, just things, because we have been friends for a long time.
But when I received this subpoena for my records, that was the first time I became aware that he was involved in this thing, you know, or that I might even be involved. I thought that was -- kind of came out of the blue. And since that time I have seen him once or twice.

1974

Q. Did someone tell you that you had to testify in this case at trial, Dr. Groff?
A. Well, I guess when I spoke to Nancy Faggianelli and we kind of agreed that I would be deposed, she said she would send a subpoena to my office. And I said, "Fine, just send it. Anybody will accept it," just after we had gotten the subpoena for records. I guess that means you must testify.
Q. Well, did you ever receive the subpoena --
A. No.
Q. -- from Ms. Faggianelli?
A. No, because that was canceled because of the discussions about the payment and so forth.
Q. Right. Well, I got off track a little bit. But who told you you had to come here today and testify? Who told you that?
A. I was not subpoenaed. I just heard it from Mr. Acosta, I suppose. He asked me if I would come.
Q. So the reason you are here is because Mr. Acosta asked you to come and talk about your treatment of Mr. Eastman?
A. Yes. Wait, wait. No, actually, the way it went was this. I received a subpoena for my records. I sent a copy of my subpoena to Mr. Acosta's office. I

kind of guessed he already knew; but just in case he

hadn't been noticed, it was the proper thing to do. After he received that is when I then received an e-mail or something with that notice. And I believe they then said -- I can't be exactly sure how it happened, but they said that I would then be all called as a witness by him because of the records that were introduced. But I don't recall anybody saying I had to go or that I would be subpoenaed.

Q. Okay.

A. I believe that was the sequence of events.

Q. And you are not here today simply because you didn't have better things to do, are you, Dr. Groff?

A. "simply because I didn't have better things to do." I'm not under subpoena. I'm here because I was asked to come here to talk about my records.

Q. By Mr. Acosta; correct?

A. By Mr. Acosta, yes.

Q. Okay. The other question that I don't think I got and answer to is when was the last time prior to this morning here in court that you actually spoke to Mr. Eastman?

A. I think a week ago.

Q. Okay. And was that a social setting?

A. Yes.

Q. All right. So it would be accurate to say

that in addition to for some six months some 23 years ago treating Mr. Eastman as a psychiatrist, thereafter the two of you developed a friendship?

A. Yes.

Q. And that's a friendship that has been maintained for some 23 years?

A. Yes.

Q. All right. Doctor, this entry for February 12th, 1980, I have looked at it and looked at it and looked at it; and I can't see a reference to cigarette smoking. Would you look at it and see if you can find one, sir.

A. I do not.

Q. Okay. February -- March 12th please now.

This is the entry for your session, all of it, for the session that you had with Mr. Eastman on March 12, 1980, correct, Dr. Groff?

A. March 12th.

Q. March 12th.

A. Yes.

Q. Let me just read the entry. I want to -- it says, "Alienation," right? "what makes me a victim," question mark. Getting in touch -- C with a line over it means "with"; right?

A. Yes.

Q. "getting in touch with feelings," semicolon. And what is that?

A. Unconscious.

Q. Unconscious?

A. "UCS" is unconscious.

Q. Okay. And what's the significance of your notation of the word "unconscious" in your records? Let me help you out. I will ask a better question because what I'm guessing --

A. Let me just try to answer this one question while I'm formulating it my mind, before you jump to another one.
Q. Sure.
A. "alienations. What makes me a victim. Getting in touch with feelings. Unconscious." Okay. I guess what I'm saying here -- and usually, you know, the way it really works in life is I would have to know what occurred in the session before and then in the session after. But if I just look a this one, what that obviously says to me is that in the course of the therapy, that we are bringing up some unconscious material. Now, that unconscious material would be the matters that we discussed but don't necessarily write down.
Q. Well, why don't you take a look at the session

immediately preceding this one --
A. Okay.
Q. -- and the session immediately following it, and tell me if there is any mention of cigarette smoking in either one of those sessions.
A. I can pretty much assure you, because I have looked over this, that the only place where I really mention cigarettes is on July 9 in writing. But I can also assure you that cigarettes are discussed or thought about and dealt with as part of therapy in every session, even though it is not written down.
Furthermore, even in the initial evaluation -- I tried to explain it earlier -- that it wouldn't be necessary for me to write down whether I discussed with the patient about obesity, alcohol, or cigarettes because that's what I do all the time.
Q. Right, Doctor. But only two people in this room were in that -- those sessions that you had with Mr. Eastman; right? There was you and there was John Eastman; correct?
A. Yes.
Q. And there is only one record of what happened in that room; correct?
A. There is this written record you mean?

Q. Yes. DX 11,000.
A. As far as I know, that's correct.
Q. And as you have indicated, there is only one reference to cigarette smoking in those two pages, those six months' worth of medical records; correct?
A. That's correct.
Q. And that reference appears the very last time you had a session with Mr. Eastman on July 9, 1980; correct?
A. That's correct.
Q. And what that --
MR. WALLACE: Can we see the July 19 -- July 24, please.
BY MR. WALLACE:
Q. This is the last session, the next session, he didn't show, and treatment was mutually terminated; correct, Dr. Groff?
A. Correct.
Q. And like you, I mean, I went through these two pages looking and looking for a reference to cigarette

smoking, and I think this is what you are referring to. This is -- the only one I found is a down arrow, which means decrease or down to; right?

A. Yes.

Q. And then it says "To less than, that's what

1980

that symbol means; correct?

A. Correct.

Q. -- "15 cigarettes per day." All right? That's the only reference to cigarette smoking in your records of your treatment with Mr. Eastman; correct?

A. Yes. In written reference.

Q. And what that suggests is that Mr. Eastman at some point appears to have set a goal to reduce his consumption of cigarettes, correct, one could draw that inference?

A. Yes.

Q. And one could equally draw the inference -- the evidence is consistent with one concluding that he achieved goal by July 9, 1980, in reducing his consumption of cigarettes to less than 15 per day; correct?

A. No, false.

Q. Tell me what is false about that.

A. We failed in our therapy to deal with his reducing his cigarettes. That note just prior to my realizing that our therapy was going to end was a morbid statement as to the failure of our therapy; and even if I wrote it or didn't write it, I can tell you that's what happened. At that point I was noting that that's all we got to, was to decrease to less than 15

1981

cigarettes per day. That would not be a worthy goal of a therapist trying to help a patient to get off of a very toxic substance. A goal that would have been more satisfactory would have been if he had terminated completely or certainly got it down to below five. And that's what that sentence is really -- or that statement, "Decrease to less than 15 cigarettes per day," is saying. It's saying that there was a failure.

Q. Okay. So in your opinion people shouldn't smoke cigarettes at all, I guess; right?

A. Yes, that's correct.

Q. All right. Do you favor a ban on cigarettes? Should they be banned?

A. Yes, I would think that cigarettes have no redeeming value, and truly it's not something that I believe personally has a value on this planet.

Q. Sure. But as a -- where did you say you went to medical school, by the way?

A. At the University of Amsterdam in Holland.

Q. Okay. Now, did they teach you at the University of Amsterdam in Holland that what one does as a psychiatrist is substitute one's own judgment for what's right and wrong and what's good and bad for those of patients like John Eastman? Is that what they taught you at medical school in Holland?

1982

A. Well, I assume that that's a rhetorical question. But, obviously, that's not what any sound educators would teach to anybody.

But I could add for your clarification, if you would like to know how it works with toxic

substances.
Q. Sir, thank you. You have answered the question.
A. You are welcome, sir.
MR. WALLACE: Could we go back to the slide 319, please.
We are almost done, Doctor.
BY MR. WALLACE:
Q. It says here, "Had a good day with radio guests. Jan, a real love affair. Is losing weight. Don't exercise. Do activities. Relationship with Jan is motive." And it says here, I guess, "Sex is an endless process" in quotes and something about respect.
But let's talk about losing weight. Do you see that entry?
A. Yes.
Q. It's in quotes. So is that something that you told Mr. Eastman he should do, or does it suggest that it was something he was telling you he had done?
A. Again, I believe that if a person felt that

they were overweight and they were in therapy, certainly it should become incorporated in the therapy to help a person look at what it meant. And it seems like, although I don't think that weight was the highest level of our agenda in our therapy, that he was reporting as progress in what he was working on, that he was able to get another one of those things in his life under control.
Q. Right. What this suggests is that Mr. Eastman had set a goal for himself of losing weight, and his motivation for doing so was his relationship with this woman named Jan, correct, according to your notes?
A. Why would you say that?
Q. Well, it says, "Relationship with Jan is motive."
A. No, actually what that says is "Relationship with Jan is mature."
Q. Okay. Well, what we have here is that your notes indicate that Mr. Eastman has set a goal for losing weight, and he chose not to do it by exercising, but rather to do it by engaging in some form of activity; correct?
A. No, actually that's my idea. At the time I felt that patients shouldn't stress themselves. I think he was just at 175 and his goal was for 165.

Q. Right.
A. That's what that note triggers my mind about. And I would tell him, "Look, don't bother to exercise. Just continue to do normal life activities." So that's the way I teach patients to do it. Because they found for those patients who were trying to lose just a little bit of weight, if they got into over-exercise, it would increase the appetite; and that wasn't really the goal. So I think that's what that's all about, by explanation.
Q. Okay. All right. Well --
A. And it was a good session in the sense that this relationship with Jan seemed to be a very mature relationship.
Q. All right. Let's look at the notes of your session on March 26.
"a frustrated doctor." Now, would that be

you, Dr. Groff, that you were a frustrated doctor at that time?

A. No. That was John. Actually, he was supposed to be a doctor.

Q. He was supposed to be a veterinarian, wasn't he?

A. Well, I think his father wanted him to be a veterinarian, as I understand it, but I think he wanted to be a doctor.

1985

Q. Whatever his goals or objectives was in that regard as a young man, he didn't achieve them, did he?

A. I beg your pardon?

Q. He didn't achieve them, did he? He didn't become a doctor, did he, Doctor?

A. Well, I don't think that he ever really wanted to become was a doctor. I think what he really wanted to become was what he became, a writer and a --

Q. Celebrity.

A. -- a celebrity, yes.

Q. All right. "a systemic thinker" in quotes. What does that mean?

A. I have no idea.

Q. Well, then help me with this one. "I deserve what I get." What does that mean?

A. Probably in the course of therapy we were discussing some really tough stuff and things that might come up from the unconscious, and who knows. But I thought it was important to see that he is now beginning to look inside himself and express some guilt about things that may have happened. And then he says, "I want to be cooperative." So basically I must be at this stage of the therapy, some two months down, getting to push some buttons and touch some nerves. In other words, we are doing real good therapy.

1986

Q. Okay. Now, there is no mention of cigarette smoking in that session, is there?

A. There is no mention of any written down of any cigarette smoking anywhere in this entire document, except on July 9.

Q. Let's go to your session on April 30th, 1980. Mr. Eastman reports that he has worked hard and succeeded; correct? Is that what that says?

A. I can't -- you are looking at April 30?

Q. April 30.

A. Oh, yes, "Has worked hard and succeeded."

Q. And then I cannot make out --

A. "two months from now will be doing two shows back to back per week. Is much less " -- that's what the two arrows down means -- "much less self-destructive and is comfortable with abstinence.

So probably this session has to do with a very successful session where we are getting somewhere, and he is feeling now for the reasons he came to me that he can handle these two shows back to back. Things are looking good. He is working very hard. He has succeeded. He is being less self-destructive. And what that note about "comfortable with total abstinence" means is that probably in our talking about -- because the major issue was smoking cigarettes, that he is now

1987

comfortable with the idea that maybe he can set a goal

for actually giving up smoking.
Q. Well, that's your recollection at this point, and you may well be right. But based upon your record, we have nothing that places the reference that John Eastman was comfortable with total abstinence, which means doing without something; right?
A. Yes, total abstinence means doing without something totally.
Q. Doing without.
A. Right.
Q. And we have nothing within the four corners of your records what you wrote at the time you were treating this gentleman that would enable the ladies and gentlemen of the jury to conclude what he was totally comfortable being abstinent about; right?
A. No. I think the ladies and gentlemen of this jury recognize that I have been talking to him about smoking cigarettes from day one and that this fits right in line with everything that I have been explaining from day one.
Q. And it turns out -- now, is that something that Mr. Eastman would have said to you or something that you would have told him, that he could find comfort in total abstinence? What is your recollection 23 years later?

A. Well, you are misinterpreting or misreading it. It doesn't say -- it says, "comfortable with total abstinence." So that means to me, using th verb in that way, that in our discussion at this stage of therapy where I'm still thinking we are on the zenith and rising to help him with his problem with smoking cigarettes, that he could start to entertain now the concept on a verbal conscious level that maybe one day he would quit.
Q. Turns out he was right; right?
A. Well, during this course of therapy, unfortunately, it turned out he was wrong.
Q. Well, but I thought what you said was that one day he might quit; right?
A. Well, if you are asking me a question, I would like to have a chance answer in the following way. Are you asking me a question?
Q. Sir, you can answer my question in any way you want, provided it is truthful?
A. Wow. Yes, it's going to be truthful, sir. And what I would like for you to understand is that I felt that Mr. Eastman is addicted today. I feel that even though he was faced with this terrible thing of chronic obstructive pulmonary disease and aneurysm of his aorta, which I'm sure was all caused by smoking cigarettes, even today -- and that was one of the things I disagreed with when I had the opportunity to look at the statement of Dr. Kaplan. I think even today he is just a guy who could wait for the shoe to fall, and that's one of the terrible parts of this addiction.

So even in my therapy when he failed -- if you are suggesting that you think today he succeeded, I would ask you to have another look at my friend and think twice about whether he succeeded or not.
MR. WALLACE: Your Honor, I move to strike that as nonresponsive of the question that was asked.

THE COURT: You told him he could ask it in any way he wanted --
MR. WALLACE: That's true. You are right.
THE COURT: -- to as long as it was honest. So you kind of opened the door for that one.
MR. WALLACE: You are right. Shame on me. Okay.
MR. ACOSTA: Move to strike, Judge --
MR. WALLACE: Do you know --
MR. ACOSTA: -- his comments to himself.
THE COURT: Sustained.
MR. WALLACE: It was unconscious.
MR. ACOSTA: Same objection.

BY MR. WALLACE:
Q. Do you know, Dr. Groff, whether Mr. Eastman to this day smokes cigarettes?
A. Well, if you mean about the deal with two people in the room and only know -- I can't really know. But I'm told that since 1995 when he was confronted with his very existence, at that moment that was strong enough to have him at least temporarily and partially to put down his last cigarette. If he were smoking today -- and there are people who have done that, despite being confronted with this situation -- I would hope and pray that you are wrong and that he is not smoking today.
Q. All right. Let's go to the last slide, July 9th, your July 9th session. And this is the last session that you had with Mr. Eastman; right?
A. Yes.
Q. And this is where he either is or he isn't down to 15 cigarettes a day, but that's what your records reflect; correct?
A. That -- my understanding of what that reflects -- and that's my usual custom -- is that he is only down to less than 15 cigarettes a day. Our goal would have been far less --
Q. Right.

A. -- if not total abstinence.
Q. Well, we don't -- we can't tell what your goals are because your records don't contain any treatment goals -- any statement of your treatment goals, do they, Dr. Groff?
A. I'm here to truthfully tell you that my records are only cryptic. My records are not meant to have statements like that. But they are here to jog my memory, and I'm telling you truthfully what's in my memory.
Q. I don't doubt your truthfulness, sir, but that wasn't my question. Your records do not contain any explicit or specific reference to what your treatment plan was for Mr. Eastman; correct?
A. That's correct.
Q. Nor do your records contain any diagnosis of any mental disorder or condition that Mr. -- Mr. Eastman was suffering from; correct?
A. Not written down as such, but I think any professional reading this could come to conclusions about diagnostic categories.
Q. And there is no reference anywhere in your records to the word "addicted," is there, Dr. Groff?

A. I don't think so.
Q. You don't think there is; correct?

1992

A. I do not think there is.
Q. All right. Let's look at this entry right here. It says that "Jan is a stabilizing factor in his life"; is that what that says?
A. "Jan, a stabilizing factor."
Q. Okay. And then what it says -- ETOH is alcohol; correct?
A. Correct.
Q. Distilled spirits, gin, vodka, scotch, whatever?
A. Alcohol.
Q. Okay.
A. Ethanol, actually. "ETOH" is a chemical symbol for ethanol.
Q. And doctors use that as a shorthand reference to alcohol?
A. That's correct.
Q. And what Mr. Eastman told you, he identified that it had been necessary for him to consume alcohol in order to have sex; correct?
A. No, that's not what that means.
Q. Why don't you tell us what that means then, please, sir.
A. That in our discussions probably earlier, as well as maybe in that session, that in the same way that

1993

some people will associate holding a cigarette in their hand and drinking, some people will associate drinking with having sex.
Q. All right.
A. If I follow that by saying "with Jan it's not necessary," then I think, although I can't be 100 percent sure, noting that Jan is a stabilizing factor, that he's simply identifying that with a person like Jan, the relationship is so good that it would never require or be identified in any way with alcohol and the sexuality that existed between them.
Q. Right. What it would seem to suggest to me is that there was a point in Mr. Eastman's life where, rightly or wrongly, he perceived or thought that it would be necessary for him to consume alcohol in order to have sex; correct?
A. No. I think if you stretched it to mean that, that's certainly not my recollection it would mean that.
Q. What does it mean, sir?
A. Just, again, what I told you a moment ago?
Q. Yes. What does it mean?
A. I feel that looking at the entire case and understanding Mr. Eastman, his relationships with women, and this one with Jan, that as this one is -- as I know, was going to be the end of our therapy and I'm kind of

1994

summarizing certain ideas about what he found out of this therapy, "Jan is a stabilizing factor, and that when we identify alcohol with sex," semicolon, "with Jan, it would not be necessary to in any way associate sexuality and alcohol, as others might do."
Q. And what that means then is that Mr. Eastman had developed the ability to disassociate drinking from sex and to realize that he could have sex with at least

one woman without there being any linkage to alcohol; correct?
A. No, I wouldn't stretch to that kind of theory. I don't see your point in that.
MR. WALLACE: No further questions, Your Honor.
THE COURT: Any redirect?
MR. ACOSTA: Can I have just one second, Your Honor?
(Pause.)
MR. ACOSTA: I think I just have one or two questions for you, Doctor.
BY MR. ACOSTA:
Q. When you saw Mr. Eastman, how long were the sessions?
A. Forty-five minutes.
Q. And did the two of you talk for 45 minutes

back and forth?
A. Hopefully, but there may have been silences at times.
Q. And so those records -- just little one-sentence, couple-sentence records -- were for what purpose?
A. It's just a habit I got into just to remember a session was on a certain day and, for example, if he had insurance to cover or -- in other cases. So it just makes a note that a session occurred on that day, but it isn't meant to really to summarize or say too much other than to jog my memory for the next time.
Q. Did John Eastman have these defense mechanisms at and unconscious level that related to his smoking?
MR. WALLACE: Objection, Your Honor. Mr. Acosta is putting words in the witness's mouth.
MR. ACOSTA: I just asked him if -- these are the topics.
THE COURT: I will permit it.
A. Yes, he did. And through the course of the therapy and in discussions, this was the meat. This was working on what was unconscious and being denied or rationalized in an attempt to bring it to the surface, an awareness.
Q. And what was the ultimate impact of these

self-defense mechanisms on his smoking?
A. I think -- in my own defense I think he learned a lot. I think it was a positive experience, perhaps, if other things didn't contaminate it, like the unfortunate situation with the real reasons he had thought he came, the business situation and his career. If they had been more stable, possibly we would have had a greater success with him giving up the smoking. But although he failed in my course of treatment, I would have hoped that it would have been a steppingstone for him to try further. Looks like it didn't.
Q. Was there anything -- when you say "giving it up," did he have a choice in doing that, considering what you know about him?
A. Well, here is the thing. Psychiatry is a medical science. It's really unworthy of the medical science to discuss the word "choice." Choice is something for laymen to discuss when they can think about and make decisions: Shall I go left? Shall I go

right? Shall I eat a piece of pie.
But when we are talking in psychiatry about addiction, then what we mean is that these people from a scientific perspective have no choice. The word "choice" does not enter into the equation.
MR. ACOSTA: Thank you, Doctor.

That's all I have.
THE COURT: All right. I think the witness may stand down.
MR. WALLACE: One moment, Your Honor?
THE COURT: Wait just a moment. We are waiting to see if they have any follow-up.
MR. WALLACE: No questions, Your Honor.
THE COURT: Okay. You are free to go, sir.
Folks, I think this would be a good time for us to take our lunch recess.
If you will be back in the jury room at about 1 o'clock, we will be ready to proceed.
Thank you.
THE BAILIFF: All rise. This court will be in recess until 1 o'clock.
(The following took place out of the presence of the jury.)
MR. WALLACE: Your Honor, are we excused for lunch?
THE COURT: You are.
MR. WALLACE: Thank you.
(At 11:41 a.m. A lunch recess was taken, after which the following proceedings were had:)

CERTIFICATE OF REPORTER

STATE OF FLORIDA)
COUNTY OF PINELLAS)

I, BETH L. BILLINGS, RPR, Deputy Official Court Reporter, in and for the Six Judicial Circuit, State of Florida:

DO HEREBY CERTIFY that the foregoing proceedings were had at the time and place set forth in the caption thereof; that I was authorized to and did stenographically report the said proceedings and that the foregoing pages, numbered 1877 through 1998, inclusive, is a true and correct transcription of said stenographic report.

IN WITNESS WHEREOF, I have hereunto affixed my official signature and seal of office this 20 day of March, 2003, at Clearwater, Pinellas County, Florida.

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BETH L. BILLINGS, RPR